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AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2013

THURSDAY, APRIL 19, 2012

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 1:58 p.m., in room SD–124, Dirksen Senate Office Building, Hon. Herb Kohl (chairman) presiding.

Present: Senators Kohl, Pryor, Brown, Blunt, Collins, Moran, and Hoeven.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOOD AND DRUG ADMINISTRATION

STATEMENT OF DR. MARGARET HAMBURG, COMMISSIONER

ACCOMPANIED BY:

- **PATRICK McGAREY, ASSISTANT COMMISSIONER, OFFICE OF BUDGET, FOOD AND DRUG ADMINISTRATION**
- **NORRIS COCHRAN, DEPUTY ASSISTANT SECRETARY, OFFICE OF BUDGET, DEPARTMENT OF HEALTH AND HUMAN SERVICES**

OPENING STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Good afternoon. The subcommittee will come to order.

Today's hearing will focus on the Food and Drug Administration's (FDA's) fiscal year 2013 budget request. We welcome Commissioner Hamburg, Mr. McGarey, and Mr. Cochran. We appreciate your being here.

Before we begin, I'd like everyone to know that we have votes scheduled for 2:15 p.m. today. So right now we'll plan on just having opening statements by myself, Senator Blunt, as well as Commissioner Hamburg. Once the votes are called, we'll have to stand in recess until the votes are through, and we'll come back then and begin our questions. So we thank everybody for accommodating that.

The administration's budget request for fiscal year 2013 stands in stark contrast to the requests of recent years. Since 2008, the Congress has provided the FDA with budget increases totaling nearly 30 percent and the administration's requests have even been higher. This year, however, the FDA budget proposes an increase of only $15 million, bringing total funding to approximately $2.51 billion.

Two main funding increases requested in this budget are $10 million to enhance inspections of drugs and drug ingredients manufactured in China, and to work with Chinese manufacturers on ways to meet FDA standards; and $18 million to complete the FDA's Life Sciences-Biodefense Laboratory complex. These increases are partially offset by decreases found elsewhere in FDA's budget.

As we are all aware, this subcommittee has worked over the past several years to provide FDA with increased funding for food safety activities. This year the only additional funds for food safety are requested in the form of a new user fee. My understanding is that negotiations on this user fee are in their earliest stages, and it is not likely to be passed this year. This means essentially that food safety activities are flat-funded in this budget, when we all know that the FDA's workload in this area has certainly not leveled off. That concerns us. I look forward to discussing this further.

I don't believe that this budget request reflects less support for FDA by the administration, but I do believe it reflects the budget realities that we continue to face. The FDA has been exempt from significant cuts found elsewhere throughout the Government. This will certainly prove to be the most difficult year in recent history. The importance of FDA's work has not diminished, and the agency's workload continues to increase. I have said in the past that I believe ensuring the safety of our food and drug supply is an important Federal function and should not and cannot be relegated to State and local governments as well as private industry.

As these functions continue to become more and more complex every day, we will do our best to provide FDA with the funding you need to do your job well, with the understanding that we are all being required to do more with less.

We look forward to your testimony, Dr. Hamburg. But first, Senator Blunt.

STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. Thank you, Mr. Chairman. Thank you for holding today's hearing on the FDA budget. I want to thank our witnesses for being here today. I look forward to working with the subcommittee, but particularly to working with the chairman, who has had such a good impact on FDA issues over his time on this subcommittee.

Commissioner Hamburg, thanks for your visit the other day. The agency you head regulates approximately 20 cents out of every $1 spent in America and Americans expect the FDA-related products will be safe and effective. Similarly, the industry expects transparency and certainty from the FDA.

The agency has authority over 185,000 domestic establishments that range from food processing plants to facilities that manufacture life-saving medications. As companies struggle through the recession, FDA must be mindful that burdensome regulations can stifle innovation and lead to unnecessary expenses that limit small businesses' ability to create jobs.

For example, FDA's currently reviewing comments on a proposed rule that would require restaurants to list calorie content for standard menu items and of course very specifically defining standard menu items so you could know what that standard was. I believe the proposed rule that you've asked for comment on and haven't finalized is at this point still unnecessarily broad and too inflexible, but hopefully the final rule will benefit from the comments you're receiving.

When implementing the rule, you should adopt the least burdensome alternatives that meet your responsibility, and doesn't unnecessarily regulate stores that don't sell food as their primary business or other things that wouldn't be necessary under the act. In addition, the rule should be flexible enough to allow locations that don't serve their patrons on site the opportunity to provide nutrition information in a variety of formats.

I look forward to being able to discuss this issue a little further.

I'd also like to take a moment to mention that this very well may be the last hearing of the subcommittee this year. Chairman Kohl has announced that he'll leave the Senate soon, I suppose maybe to focus on basketball full-time or one of his other many activities that he's involved in. But this may be his final hearing as chairman. We're going to continue to work closely together to produce a bill.

I'd like to say that in leading this subcommittee he's really displayed keen knowledge of all the work of the subcommittee and—as you know, Commissioner—has shown particular interest and has been a real leader on FDA issues, particularly on food safety, and really, it's been an honor for me to get to work with him last year. I hope we produce a bill this year that we can get to the floor again, and we'll both be out there doing what we can to make this subcommittee work under the chairman's leadership.

Thank you, Mr. Chairman.

Senator KOHL. Thank you. Thank you, Senator Blunt.

Now, Dr. Hamburg.

STATEMENT OF DR. MARGARET HAMBURG

Dr. HAMBURG. Thank you, Chairman Kohl and Ranking Member Blunt. I do also want to take this opportunity to thank you, Chairman Kohl, for the extraordinary leadership that you've shown over so many years and the support you've given the FDA in our important mission.

I am joined, as you note, by Patrick McGarey, who is our Assistant Commissioner for Budget, and Norris Cochran, who's Deputy Assistant Secretary for Budget at the Department of Health and Human Services (HHS).

Let me begin by again thanking you and the subcommittee for your efforts in recent years to really try to shrink the gap between the agency's budget and its vast and evolving responsibilities. Your leadership has put us on a path towards more appropriate funding levels to support our unique and crucial mission. We are using these funds responsibly to reinforce our core functions and to obtain the most public health value for the Federal dollar during these challenging fiscal times. We're deploying smarter and more flexible regulatory approaches and better targeting of our inspectional resources. We've consolidated our information technology (IT) infrastructure into modern data centers and expanded our efforts to leverage both financial and human capital through collaborations with public and private partners.

DRUG APPROVALS

With your support, we have produced concrete results that really matter. For example, we lead the world in the number and speed of drug approvals, while maintaining high standards for safety and efficacy. Last year we approved 35 innovative new drugs, many of them groundbreaking, the second highest number of approvals in more than a decade.

During this fiscal year, we've continued our strong performance and have already approved 15 innovative new drugs and biologics. Last year a total of 195 drug shortages were prevented through proactive collaboration with patients, healthcare providers, and manufacturers, and by exercising regulatory flexibility. This year we've already prevented another 30 drug shortages.

FOOD SAFETY MODERNIZATION ACT

Just 1 year after the enactment of the Food Safety Modernization Act, we've issued guidances and interim final rules and are on the way to meeting the 5-year inspection mandate for high-risk domestic facilities.

I think it is critical to note, though, that the volume and complexity of the products we regulate and the complexity of the supply chains by which they reach American consumers has increased dramatically. We receive thousands of medical product submissions each year and serve as the watchdog for the safety of tens of thousands of products that are already in the marketplace, and we oversee the safety of roughly 80 percent of the Nation's food supply. Imports of food products alone come from some 200 different countries and from more than 250,000 foreign facilities each year.

GLOBALIZATION

In addition, our core responsibilities are expanding to include additional product areas, such as tobacco, and evolving to accommodate scientific and technological advances and the challenges of globalization. Our budget request reflects these complexities and new demands, although, as you note, it is modest.

FISCAL YEAR 2013 BUDGET

The fiscal year 2013 budget recommends $4.5 billion for FDA overall, a 17-percent increase from fiscal year 2012. User fees account for 98 percent of the increase, however. We're proposing cuts or savings in two areas, IT and related systems and building and facilities. FDA is also absorbing more than 80 percent of inflationary rent costs.

Our fiscal year 2013 budget authority increases will support import safety, medical countermeasures, White Oak facilities, the commissioned corps pay raise, and about 20 percent of our rent increase.

BUDGET REQUEST

To strengthen the safety of foods and drugs from China, FDA is requesting $10 million. Exports from China are experiencing unprecedented growth. In the last 5 years alone, shipments of FDA-regulated products from China increased by 62 percent. So that represents a fundamental shift of our economic and security landscape. These additional resources will strengthen our capacity to inspect Chinese facilities and our ability to work with our colleagues in China and our ability to perform risk analysis on Chinese exports.

MEDICAL COUNTERMEASURES

Thanks to this subcommittee, FDA received a fiscal year 2012 appropriation of $20 million for medical countermeasures. The fiscal year 2013 budget recommends an additional $3.5 million to support development and review of new diagnostics, medical treatments, vaccines, and other technologies against a range of naturally occurring or deliberate chemical, biological, radiological, or nuclear threats, and new funding will help support initiatives focused on acute radiation syndrome, the needs of children and pregnant women, in vitro diagnostic tests, and building flexible medical countermeasure manufacturing capacity, and allow us to continue other ongoing efforts.

LIFE SCIENCES-BIODEFENSE LABORATORY

The President's budget also proposes an increase of $17.7 million to outfit the new Life Sciences-Biodefense Laboratory and ensure that all of the biosafety systems are operational before we occupy and can use the laboratory.

USER FEES

User fees clearly represent a substantial part of our fiscal year 2013 budget and I want to address that briefly. The current user fee programs for drugs and medical devices expires, as you no doubt know, on September 30 of this year. The reauthorization process is now well under way and new user fee programs for generic drugs and biosimilars have also been put forward.

FOOD SAFETY MODERNIZATION ACT

But to implement the Food Safety Modernization Act and reduce the burden of food-borne illness on consumers and American food producers, a new food facility registration fee that would generate $220 million has been proposed. Additional proposals include new user fees to support the cosmetic and food contact substance programs, to compensate FDA for medical product reinspections, and support import operations at courier hubs.

PREPARED STATEMENT

So, to conclude, let me emphasize that the resources in this budget are vital to our efforts to ensure timely access to innovative products, as well as our commitment to protecting the public from unsafe food and ensuring safe, effective medical products.

I appreciate your time and attention and will be happy to answer any questions you may have after you come back from your vote.

[The statement follows:]

PREPARED STATEMENT OF DR. MARGARET HAMBURG

Chairman Kohl, Senator Blunt and members of the subcommittee, I am Dr. Margaret Hamburg, Commissioner of the U.S. Food and Drug Administration. I am pleased to present the President's fiscal year 2013 budget request for the Food and Drug Administration (FDA).

I want to begin by thanking you for your efforts over the past few years to shrink the gap between the FDA's budget and its vast and evolving responsibilities. We have made every effort to spend those funds responsibly—to reinforce core functions and obtain the most public health value for the dollar.

As a science-based regulatory agency of global scope, FDA's mission is both exciting and daunting. Our core responsibilities are evolving and expanding to include additional product areas such as tobacco, to accommodate scientific and technological advances, and to step up to the global leadership role that FDA must play if we are to promote innovation and protect American consumers.

Our recent spending and new budget requests reflect this evolution. We are embracing these changes in several important ways—by deploying smarter and more flexible regulatory approaches, by identifying efficiencies and innovative approaches to deliver our core mission, improve outcomes, and better target our resources, and by using collaborations to leverage expertise, data, and experience. Through these approaches, we are already improving efficiency and achieving concrete results. While the challenges loom large, we are confident that we have identified investments and approaches that will allow us to continue this evolution and to protect and promote the public health.

FDA INVESTMENTS AND RESULTS

With the funding you have provided, FDA has delivered significant and quantifiable benefits for the American people, and we are very proud of these achievements.

In the area of drugs, FDA now has the highest first action approval rate for new drugs we have ever achieved, and we continue to look for ways to improve the predictability, consistency, and transparency of our drug review process. During fiscal year 2011, we approved 35 innovative drugs, many of them ground-breaking. This was the second-highest number of approvals in the past decade. These drugs represented real advances for patients, including breakthroughs in personalized medicine. They include two novel drugs that were developed and approved with diagnostic devices that will allow doctors to target the drug to those patients most likely to respond, as well as new drugs to treat important medical conditions.

To achieve these results and to speed access to the American people, we demonstrated regulatory flexibility, using, for example, accelerated approvals and innovative clinical trial designs. Of note, we lead the world in the number and speed of drug approvals. Of the 57 novel drugs approved by both FDA and the European Union between 2006 and 2010, 75 percent were approved first in the United States. Furthermore, between 2003 and 2010, all 23 cancer drugs approved by FDA and the European Union were approved first in the United States by FDA.

During fiscal year 2012, we continued our strong performance. Since October 1, FDA approved 15 innovative drugs and biologics. Of the 15, 11 (or 73 percent) were approved in the United States first. Fourteen of these products had Prescription Drug User Fee Act (PDUFA) deadlines, and we met the PDUFA deadline for 13 of the 14 products (that is, we met the PDUFA deadline 93 percent of the time). Just as important, of the 15 innovative drugs and biologics, 12 were approved on the first cycle, for an 80-percent first-cycle approval rate.

Some specific information on individual drug approvals will provide context for the importance of these actions. During January 2012, FDA approved a truly breakthrough product in the field of personalized medicine, a drug to treat a rare form of cystic fibrosis. Known as ivacaftor and sold under the trade name Kalydeco, this drug only works for patients with a certain genetic mutation. But, thanks to advances in personalized medicine, physicians can identify patients with this mutation. This allows doctors to use Kalydeco only for patients where the drug will be effective. For patients who respond to this drug, it can keep their lungs clear, help them breathe, and make an enormous difference in the quality of their lives.

The FDA drug review process normally takes about 10 months. But in the case of Kalydeco, a drug of great importance for patients in need, this drug was approved in less than 4 months.

FDA approved another drug in January 2012. Known as vismodegib and sold under the trade name Erivedge, it is the first FDA-approved drug for metastatic basal cell carcinoma, the most common type of skin cancer. This new drug interferes very little with the growth of healthy cells, but works by disrupting the molecular pathway in the body that causes cancer cells to grow. Given there were no available treatments at the time, FDA took measures to expedite its approval. As a result, Erivedge was approved in less than 5 months—or half the time of a typical FDA approval.

We have also been working aggressively to address and prevent drug shortages and to implement important Presidential directives. On October 31, 2011, the President issued an Executive order that directed FDA to take action to help further reduce and prevent drug shortages. In 2011, FDA successfully prevented at least 195 drug shortages. During the first 3 months of 2012, FDA prevented 22 shortages. FDA has sent letters to pharmaceutical manufacturers, reminding them of their legal obligations to report certain discontinuances to FDA, and urging them to voluntarily notify FDA of all potential disruptions of the prescription drug supply, even when not required by law. This has resulted in a significant increase in the number of potential shortages reported to FDA, and thus enhanced our ability to take action. In February of this year, we announced a series of steps to increase the supply of critically needed cancer drugs that were in short supply, including exercising enforcement discretion for the temporary importation of an alternative drug and approving a new manufacturer on an expedited basis.

We are also playing our part to address the rising costs of healthcare, by implementing a new approval pathway for biosimilar biological products and a user fee program to support review and evaluation of biosimilar products. We are also proposing a new generic drug user fee program that will support faster, more predictable reviews for generic drugs, effectively eliminate the current generic application backlog, and help assure quality by providing resources for regular surveillance inspections of manufacturers of generic drugs.

In the area of medical devices, in 2011, FDA released the Plan of Action for Implementation of 510(k) and Science Recommendations, which contained 25 specific actions that we would take in 2011 to improve the predictability, consistency, and transparency of our premarket programs. Seventy-five percent of those actions, plus eight additional actions, are already completed or well underway. We issued guidance on FDA's regulatory expectations for personalized medicine diagnostic devices that are developed along with a therapeutic product, to target that therapeutic product to the appropriate population. We launched the Innovation Initiative, which proposed actions that FDA could take to help accelerate and reduce the cost of developing and evaluating innovative medical devices, using science-based principles to maintain or improve patient safety.

In the area of food safety, the most sweeping reform of our food safety laws in more than 70 years was signed into law by President Obama on January 4, 2011—the FDA Food Safety Modernization Act (FSMA). We issued an interim final rule describing the criteria for administrative detention of food when there is reason to believe the food is adulterated or misbranded, and we have used this authority several times. We met the 1-year FSMA mandate for inspections of foreign facilities, and are well on the way to meeting the 5-year inspection frequency mandate for high-risk domestic food facilities. We also issued an updated guidance for the seafood industry on food safety hazards. We anticipate issuing several proposed rules called for in FSMA shortly. We post regular progress reports on implementation milestones on our Web site.

In the area of tobacco, we have been working to achieve a number of significant public health goals since enactment of the Tobacco Control Act of 2009. These include restricting youth access to cigarettes and smokeless tobacco, encouraging youth and adults who use tobacco products to quit, providing accurate information on the contents of tobacco products and the consequences of tobacco use to the public, and using regulatory tools to protect kids from initiating tobacco use and to begin to reduce the public health burden of tobacco in the United States.

We also have been aggressively and systematically addressing challenges that affect all products that FDA regulates. In June 2011, FDA issued our "Pathway to Global Product Safety and Quality" report, describing the challenges of regulating in the globalized world in which FDA now operates, calling for a paradigm shift in how we approach our duties in light of such challenges, and describing the concrete actions we will take in four areas:

—Assembling global coalitions of regulators dedicated to building and strengthening the product safety net around the world;

—Developing a global data information system and network in which regulators worldwide can regularly and proactively share real-time information and resources across markets;
—Expanding FDA's capabilities in intelligence gathering and use, with an increased focus on risk analytics and thoroughly modernized IT capabilities; and
—Effectively allocating FDA resources based on risk, leveraging the combined efforts of Government and industry.

The essence of this strategy marries creative international coalitions with cutting-edge investigative tools to continue to provide the consistently high level of safety and quality assurance the public expects—and deserves.

MAXIMIZING THE IMPACT OF FDA FUNDS

At this time of fiscal restraint, FDA is focusing on its core responsibilities and working to identify opportunities to streamline activities and leverage human and financial resources.

I have instituted a series of reorganizations designed to ensure that FDA better reflects its evolving responsibilities, but that also recognizes our responsibility to make the most efficient use of our limited resources. Early in my tenure, I appointed a new Deputy Commissioner for Foods, to ensure coordination of our growing and rapidly evolving responsibilities for oversight of the domestic and global food supply chain.

Last year I created the new position of Deputy Commissioner for Global Regulatory Operations and Policy, to fully address the need to integrate domestic and foreign inspections, streamline procedures, and seek greater harmonization and opportunities for collaboration with our counterparts in other countries. I also appointed a new Deputy Commissioner for Medical Products and Tobacco, reflecting our recognition that the review of medical products increasingly cuts across center boundaries and that a new framework was necessary to address challenges like personalized medicine and combination products. Together, these changes build efficiencies into our organizational structure from the ground up and will make it easier to identify new opportunities for streamlining in the years to come.

We have made significant progress in consolidating our IT infrastructure into modern data centers. Simultaneously, we have modernized and standardized our hardware and software infrastructure, resulting in savings in power consumption and the ability to use FDA equipment and IT support resources more efficiently. You will see savings from this consolidation reflected in our proposed budget for fiscal year 2013, as well as additional proposed savings.

Another key area for improved efficiencies is improved targeting of inspection resources. We have been working hard to ensure that our import inspection programs are risk-based, targeting imports at port-of-entry more efficiently. We are redeploying current food inspection resources and pursuing efficiencies to support initial implementation of FSMA.

PREPARING FDA FOR THE CHALLENGES AHEAD

FDA's mission is challenging, even in the best of times, with scientific advances occurring at breakneck speed and the pace of globalization accelerating. Our responsibilities are vast and growing, a trend that will only continue. We receive thousands of medical product submissions each year, and serve as the watchdog for tens of thousands of products on the market, ensuring that they continue to meet the highest standards.

We have evolved from a country that once consumed simple, primarily domestically produced goods to one that consumes complex products manufactured in every corner of the globe. We enjoy a greater variety of products from a greater range of places than ever before. The complexity of the products we regulate and the complexity of the supply chains by which they reach the eventual consumer has only increased. All of this means that FDA's job has gotten more complex and the stakes have continued to increase.

As our fiscal year 2013 budget notes, FDA regulates more than $450 billion of domestic and imported foods. Nearly 40 percent of the drugs Americans take are made overseas, and about 80 percent of active pharmaceutical ingredients are imported. Food imports have increased nine-fold since 1993. These food imports come from more than 250,000 foreign facilities in 200 countries. About 70 percent of seafood and about 35 percent of fresh produce consumed in the United States comes from foreign countries.

We are grateful that Congress has begun to help give FDA the tools needed to effectively regulate in a modern, complex, globalized environment. We are on the right path, but the road is long and challenging. The proposed fiscal year 2013 budget, described in more detail below, will continue the forward motion that you have supported.

FDA FISCAL YEAR 2013 BUDGET REQUEST

Fiscal Year 2013 Summary

The fiscal year 2013 budget recommends $4.5 billion for FDA, a 17-percent increase from fiscal year 2012. The fiscal year 2013 increase for user fees, including increases for current law user fees and amounts for seven new user fee programs, accounts for 98 percent of the FDA budget increase.

FDA user fee programs support safety and effectiveness reviews of human and animal drugs, biological products, medical devices, and other FDA-regulated products. Fees also allow FDA programs to achieve timely and enhanced premarket review performance. Finally, fees support the programs and operations of the FDA Center for Tobacco Products.

For fiscal year 2013, FDA is proposing savings in two areas—information technology (IT) and the FDA Buildings and Facilities (B&F) account. In addition to these budget authority reductions, FDA is also absorbing more than 80 percent of the inflationary cost of rent activities.

After accounting for these savings, the net increase in budget authority is $11.5 million for fiscal year 2013. Our increases support import safety, medical countermeasures, White Oak laboratory facilities, a portion of the increased cost of our rent activities, and the military pay raise that FDA Commissioned Corps officers will receive.

The Federal investment in FDA is small compared to the breadth of our mission and the $2 trillion in products that we regulate. The investment in FDA is also an investment in the economic health of two of the largest sectors of America's economy: The U.S. food industry and the medical products industry.

FDA Budget Authority

Fiscal Year 2013 Budget Reductions

FDA made significant progress in recent years to consolidate our IT infrastructure into modern data center facilities. During the consolidation, FDA modernized and standardized its hardware and software infrastructure. This effort provides an FDA computing environment that reduces our costs and provides agility not previously possible. The result is savings in power consumption and more efficient use of FDA equipment and resources for IT support.

Under this fiscal year 2013 initiative, FDA will realize savings that flow from the consolidation effort. FDA will generate additional IT savings by streamlining other data management activities, reducing redundant IT devices, and reducing other IT costs, for a total savings of $19.7 million. Finally, FDA will also save $3.5 million by deferring repair and maintenance projects supported by our Building and Facilities account.

Food and Drug Imports From China

FDA is requesting a budget authority increase of $10 million to strengthen the safety of foods, drug products, and ingredients exported from China to the United States. From fiscal year 2007 to 2011, the number of shipments of FDA-regulated products from China increased by 62 percent. This represents a fundamental change in our economic and security landscape, a change that requires FDA to alter its approach to protecting the health of the American public. To address this change, FDA must strengthen its capacity to inspect Chinese facilities that ship products to the United States and strengthen its ability to perform risk analysis on FDA-regulated products from China.

The addition of $10 million will strengthen FDA's ability to protect American consumers and patients in important and fundamental ways.

—FDA will improve its food and drug inspection and analytical capabilities with 16 additional inspectors in China, and by adding three United States-based analysts.

—FDA will broaden the range of its inspections. In addition to inspecting Chinese facilities that manufacture food and medical products for export to the United States, FDA will inspect sites of clinical trials.

—FDA will strengthen the understanding of Chinese regulators and the exporting industry about U.S. safety standards through targeted workshops and seminars. This process will foster a constructive dialogue on improving the safety and quality of food and medical products.

With these resources, FDA will develop more robust knowledge about the complexities of regulatory pathways and supply chains within an increasingly globalized environment. This understanding will allow FDA to make better evidence-based decisions and allocate FDA resources based upon risk.

FDA Medical Countermeasures Initiative

The FDA Medical Countermeasures Initiative (MCMi) is designed to help meet America's national security and public health requirements for medical countermeasure (MCM) readiness. MCMs include drugs, vaccines, diagnostics, and other medical products needed to respond to chemical, biological, radiological, nuclear (CBRN) threats and emerging infectious diseases.

Thanks to the efforts of this subcommittee, FDA received an appropriation of $20 million in fiscal year 2012 to provide a base of funding for FDA's MCMi. For fiscal year 2013, the FDA budget includes an additional $3.5 million for FDA medical countermeasures activities.

With the fiscal year 2012 base funding and the additional fiscal year 2013 resources, FDA will support partnerships with industry, academia, and Government partners to improve the development timelines and success rates for MCMs. FDA will also expand technical assistance to developers of the highest priority MCMs.

The top priorities for these MCM funds include FDA action teams to support the development of MCMs to address the following MCM needs:

—Warfighter care for American soldiers exposed to trauma or CBRN threats;
—Diagnosing and treating the multiple manifestations of acute radiation syndrome;
—Meeting the special needs of pediatric patients and pregnant women;
—Developing next generation in vitro diagnostic tests for CBRN threats; and
—Working closely with HHS to establish flexible manufacturing capacity in the United States.

Since the announcement of the FDA MCMi in August 2010, FDA and its drug, device and biologics programs have worked aggressively to ensure that the United States has access to high-priority MCMs during a public health emergency. Although less than 2 years old, FDA's MCMi has an impressive list of accomplishments, made possible by the resources that this subcommittee approved.

FDA Regulatory Science Facilities

On August 18, 2010, the General Services Administration (GSA) awarded the construction contract for the new laboratory complex at White Oak, and construction is well underway.

An fiscal year 2013 increase of $17.7 million will allow FDA to outfit the new Center for Biologics Evaluation and Research (CBER)–Center for Drug Evaluation and Research (CDER) Life Sciences-Biodefense Laboratory complex that will support FDA's core regulatory science needs. FDA must make this investment now to ensure that all laboratory biosafety hazard systems are operational and the laboratory is ready for occupancy during fiscal year 2014.

Pay and Rent

The fiscal year 2013 budget also contains $1.5 million to support the military pay increase for Commissioned Corps personnel serving at FDA and $2.0 million to pay a portion of the inflationary rent costs for FDA for FDA programs. Funding these elements of the fiscal year 2013 budget will help ensure that FDA can retain the professional staff to perform our mission of protecting patients and consumers and improving public health.

FDA User Fees

Prescription Drug User Fees

In January 2012, the Administration submitted legislation to Congress to reauthorize the Prescription Drug User Fee Act (PDUFA). The proposed legislation recommends $713 million in PDUFA fees for fiscal year 2013. The current law expires on September 30, 2012, and FDA is ready to work with Congress to ensure timely reauthorization of this vital program. To sustain and build on our record of accomplishments, reauthorization must occur seamlessly, without any gap between the expiration of the old law and the enactment of PDUFA V. The resources in PDUFA V will allow FDA to review and approve new and innovative therapies for patients, without compromising the FDA's high standards for demonstrating safety, efficacy, and quality of new drugs prior to approval.

Medical Device User Fees

For more than a year, FDA met with stakeholders and held discussions with the medical device industry in an effort to develop a package of recommendations to reauthorize the Medical Device User Fee Act (MDUFA). On February 17, 2012, FDA reached an agreement with representatives from the medical device industry, and published draft recommendations to reauthorize MDUFA on March 15. The agreement would authorize FDA to collect $595 million in user fees over 5 years, an amount that is subject to inflation increases. The agreement would also result in an fiscal year 2013 MDUFA fee amount is $97.7 million.

The agreement strikes a careful balance between what industry agreed to pay and what FDA can accomplish with the proposed funding. We believe that it will result in greater predictability, consistency, and transparency through improvements to the review process.

Key features of the agreement include:

—Earlier, more transparent and more predictable interactions between FDA and applicants, both during the early product development stage as well as during the review process;

—More detailed and objective criteria for determining when a premarket submission is incomplete and should not be accepted for review;

—More streamlined FDA review goals that will provide better overall performance and greater predictability. This includes a commitment to provide feedback to an applicant if FDA's review extends beyond the goal date, so that the parties can discuss how to resolve any outstanding issues;

—Additional resources to support guidance development, reviewer training and professional development, and an independent assessment of the premarket review process to identify potential enhancements to efficiency and effectiveness;

—More detailed quarterly and annual reporting of program performance; and

—A commitment between FDA and industry to reduce the total average calendar time to a decision for premarket approvals (PMAs) and 510k applications.

New User Fees for Generics and Biosimilars

In addition to recommending the reauthorization of PDUFA and the Medical Device User Fee and Modernization Act (MDUFMA), the fiscal year 2013 budget recommends new user fee programs to support review and related activities for generic drugs and biosimilars. The proposed user fee programs for generic drugs and biosimilars are modeled on the successful PDUFA program, but are tailored to reflect the unique challenges and needs associated with regulating generic drugs and biosimilars.

Generic Drug User Fees.—As a result of the Drug Price Competition and Patent Term Restoration Act of 1984, commonly known as the Hatch-Waxman Amendments, America's generic drug industry has been developing, manufacturing, and marketing—and FDA has been reviewing and approving—lower cost versions of brand-name drugs for more than 25 years. This legislation and the industry it fostered are a true public health success.

Last year, approximately 78 percent of the more than 3 billion new and refilled prescriptions dispensed in the United States were filled with generics, yet those drugs accounted for only 25 percent of prescription drug spending. In the last decade alone, generic drugs have provided more than $931 billion in savings to the Nation's healthcare system.

The number of generic drug submissions sent annually to FDA has grown rapidly, reaching another record high during fiscal year 2011, including nearly 1,000 ANDAs. The current backlog of pending applications is estimated to be more than 2,500. The current median time to approval is approximately 31 months, although this includes time that the application is with the sponsor to address FDA questions about the application.

The Generic Drug User Fee Act (GDUFA) proposal submitted to Congress in January 2012 will put FDA's generic drugs program on a firm financial footing and provide $299 million in additional resources to ensure timely access to safe, high-quality, affordable generic drugs.

Biosimilars User Fees.—A successful FDA biosimilars review program will spark the development of a new segment of the biotechnology industry in the United States. To advance this opportunity, the fiscal year 2013 budget includes a proposal for biosimilar user fees of $20.2 million.

The proposed biosimilars user fee program will generate fee revenue in the near-term and enable sponsors to have meetings with FDA early in the process of developing candidates for biosimilar biological products. With these fees, FDA will develop the scientific, regulatory, and policy infrastructure necessary to review biosimilar biological product applications.

Implementing FSMA—The Fiscal Year 2013 Food Establishment Registration Fee

Food Safety remains a critical program area for FDA. FDA's fiscal year 2013 proposal for food safety aims to advance the vision of a strong, reliable food safety system that Congress enacted in the landmark FDA Food Safety Modernization Act of 2011 (FSMA). The fiscal year 2013 budget proposal builds on the food safety increases that the subcommittee appropriated for fiscal year 2011 and fiscal year 2012 and calls for user fee revenue to allow FDA to establish a prevention-focused domestic and import food safety system, consistent with FSMA.

FSMA set out a vision for a modern food safety system that shifts the focus to preventing food safety problems, rather than relying primarily on reacting to problems after they occur. Implementing Congress' vision for a strengthened food safety system represents a dramatic expansion of FDA's workload. However, the simple truth is that FDA cannot meaningfully deliver on these mandates without the funding contained in the fiscal year 2013 budget.

The fee will support:

—Establishing new, effective, and comprehensive food safety standards;
—Establishing a new program for import safety;
—Increasing the number and efficiency of inspections;
—Launching an integrated national food safety system with States and localities;
—Expanding research activities, which will include improved data collection and risk analysis; and
—Improving FDA's capability to conduct risk-based decisionmaking.

These fees will allow FDA to reduce the risk of illness associated with food and feed and decrease the frequency and severity of food- and feed-borne illness outbreaks. With these fees, FDA can reduce instances of contamination and greatly diminish the burden on American businesses and the U.S. economy due to foodborne illness events. Without sufficient and reliable fee revenue, we can expect the unacceptably high human toll of foodborne illness to continue, with the resulting disruptions to the food system and the economic burdens to the food industry that result from foodborne illness outbreaks.

Tobacco Product User Fees

On June 22, 2009, President Obama signed the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) into law. Since 2009, the user fees authorized in the statute have allowed FDA's Center for Tobacco Products (CTP) to hire Center leadership and enable those leaders to initiate the scientific, educational, enforcement, and regulatory activities needed to accomplish the public health goals of the Tobacco Control Act. By the end of fiscal year 2011, the CTP had a staffing level of over 230 FTEs, and the Center anticipates meeting projected staffing goals in fiscal year 2013.

The fiscal year 2013 budget request for the Tobacco Program, including resources for CTP, is $505 million, an increase of $28 million above the fiscal year 2012 enacted budget. The amount requested is specifically authorized in the Tobacco Control Act and comprised entirely of tobacco user fees. Fiscal year 2013 priorities include protecting youth from tobacco, encouraging current users to quit, and making existing tobacco products less harmful.

Other New User Fee Proposals

Cosmetics User Fee.—The proposed cosmetic user fee of $18.7 million will strengthen FDA efforts to protect public health by preventing harm to consumers, ensuring the safety of cosmetics and removing unsafe cosmetics from the market. With this fee revenue, FDA will develop necessary guidance and standards for industry. The fee revenue will also allow FDA to identify research gaps, such as gaps related to the safety of novel ingredients used in cosmetics.

Medical Product Reinspection User Fee.—The FDA Food Safety Modernization Act, which Congress enacted in December 2010, authorized fees for reinspections of food and feed establishments. FDA is proposing to expand this fee authority to medical product establishments. With this change, medical product establishments will pay the full cost of reinspections and associated follow-up work. FDA will impose the user fee when FDA reinspects facilities due to a failure to meet Good Manufacturing Practices (GMPs) or other important FDA requirements. The fiscal year 2013 estimate for medical product reinspection user fees is $14.7 million.

Food Contact Notification User Fee.—FDA has statutory responsibility for the safety of all food contact substances in the United States. The Food Contact Notification (FCN) program supports applications for innovative food contact substances that help mitigate microbial food contamination and provide consumers with more healthful and safe food choices. The proposed user fees of $4.9 million will support FDA efforts to increase the availability of safe food contact substances, to prevent unsafe food contact substances from reaching the market and to apply the most modern regulatory science to the review of food contact substances.

International Courier Use Fee.—For fiscal year 2013, FDA is proposing a new International Courier User Fee of $5.6 million. The proposed fee will support activities associated with increased surveillance of FDA-regulated commodities at express courier hubs. To address the growing volume of imports entering through international couriers, FDA is proposing to pay the increased cost of its international courier activities through user fees.

CONCLUSION

The resources in this budget will allow FDA to perform its fundamental public health responsibilities in new and more efficient ways. Our budget also supports industry efforts to innovate and bring new products to market that will benefit American patients and consumers and strengthen our economy.

My goal with this proposed fiscal year 2013 budget is to position FDA to seize these opportunities. The resources in this budget will allow FDA to perform its core public health responsibilities in more efficient ways, to address these and the many other challenges at the heart of our mission. This budget also supports industry efforts to innovate and bring new products to market that will benefit American patients and consumers and strengthen our economy.

Thank you for the opportunity to testify. I am happy to answer your questions.

Senator KOHL. Thank you, Dr. Hamburg. The vote has been, at least for a while, postponed. So we'll just——

Dr. HAMBURG. Oh, okay.

Senator KOHL [continuing]. Start out with our questions.

Dr. HAMBURG. Excellent.

FOOD SAFETY MODERNIZATION ACT

Senator KOHL. Dr. Hamburg, this budget request assumes $220 million in additional funding that theoretically would be used to implement to the Food Safety Modernization Act. However, as you said, that funding increase would come in the form of a new user fee that has already been rejected by the Congress and that essentially has no chance of being authorized this year.

So what that really means is that this budget doesn't include any funding increase to implement the Food Safety Modernization Act, which is of great concern to many of us. How have you been working with both the Congress and the industry in order to get these user fees authorized?

Dr. HAMBURG. It is extremely important, as you note, to continue to implement the Food Safety Modernization Act, which gives us a chance to really reorient our whole food safety system towards preventing problems before they occur, rather than addressing them after the fact, which will have huge benefits both in terms of human health and reducing costs to the healthcare system, to the workplace, and to industry.

We are talking with industry about the importance of this work. They understand it. These are difficult, challenging economic times, however. We all recognize that. And we are, of course, working with other potential partners as we implement the Food Safety Modernization Act. We have made progress. We will continue to make progress, but we will have to prioritize in the context of reduced resources, and it will mean that we cannot accomplish all of the goals of the Food Safety Modernization Act, and I think it will mean that, unfortunately, we will not be able to put in place systems that would prevent disease and economic burdens as well.

But we hope that, though the process may take more time than we would like, we will continue to make progress in terms of the implementation of user fees. It's not inappropriate, I think, when you look at the common good, the benefits to industry, as well as the benefits to the public, that support for this program be a shared responsibility. We've seen the benefits of user fees with our drug user fees and more recently the device user fees, and I do believe that when you look at the amount of resources available to support food safety in this country, we clearly need to do more.

Senator KOHL. But your budget assumes $220 million necessary to discharge your responsibilities, but to be raised in the form of user fees which, let's be honest, isn't going to happen this year—$220 million. How do you propose to even come close to discharging your responsibilities without that $220 million?

Dr. HAMBURG. As I said, we are going to have to make very difficult choices. We are not going to be able to do all the things the Congress has asked us to do and that the American people expect us to do. We will place our emphasis and our resources on the highest priority issues. We do need to respond to the challenges of globalization and start to really ensure that import safety system—we will be taking more risk-based approaches so that we're targeting resources where the greatest need is, where the greatest risk is. We'll be working with States. We'd hoped to have resources to actually give to States as we build those partnerships for an integrated food safety system. That will be less possible, but we will have to find ways to work with State health and agriculture departments.

And we will have to work closely with industry and they will have to fully step up to the plate as partners. This is going to be a very, very challenging budget to implement and it will put very difficult choices in front of the Commissioner and her team.

GENERICS

Senator KOHL. All right. One question on generics, then I'll turn to Senator Blunt. This budget request assumes the collection of $299 million in new user fees for approval of new generic drugs. Assuming these fees are authorized—and we are more optimistic in this case that they will be, as you know—how long will it take to eliminate the backlog of generic drug applications that could immediately then be marketed?

Dr. HAMBURG. This is such an exciting and important opportunity to really move the generics program and its proven benefits to the next level. At the present time, we have unacceptable lags in the review of generic drugs, and we're also faced with the increasing challenge that so many of the manufacturers of generic drugs or components of generic drugs are overseas and we really have to level the playing field in terms of domestic and overseas inspections.

This user fee will enable us to do both. We've committed to reducing the review lag, which currently it takes an average of 30 months to review a generic application. We're going to bring that down to 10 months. We're committed to doing that in the 5-year span of this user fee program. And we also have committed to having equity between domestic and foreign inspections over that same time period.

Senator KOHL. Thank you very much.

Senator Blunt.

Senator BLUNT. Thank you, chairman.

Commissioner, on the $220 million of additional fees, in that fee category what's produced now in the current fees, and the ones that expire at the end of this fiscal year? You have fees that expire at the end of this year. What do they produce?

Dr. HAMBURG. The fees that would expire in September of this year are the drug user fees.

Senator BLUNT. The drug fees.

Dr. HAMBURG. And the medical device user fees.

Senator BLUNT. So you have no fees in the food safety issue, right?

Dr. HAMBURG. We don't have an establishment fee, which is what is being recommended in this budget at the current time, no.

REINSPECTION FEE

Senator BLUNT. What kind of fees do you——

Dr. HAMBURG. There's one very small fee, which I have to turn to—reinspection. There's a reinspection fee in the food safety program.

Senator BLUNT. And the reinspection fee——

Dr. HAMBURG. But it's a very small amount of money and it's for after there have been problems in a facility and we go back in and reinspect to see if they've been corrected.

Senator BLUNT. So with that exception, there are no fees——

Dr. HAMBURG. Right.

Senator BLUNT [continuing]. Now, where you're proposing the $220 million in fees?

Dr. HAMBURG. Yes.

Senator BLUNT. Would that be the same for the cosmetics? Are there fees there now?

Dr. HAMBURG. That's correct, there is not a cosmetics fee.

Senator BLUNT. And that's $18 million?

Dr. HAMBURG. $18.7 million, I think, yes.

Senator BLUNT. And what would the potential collection cost of that $18 million be?

Dr. HAMBURG. I think that the——

Senator BLUNT. To put the fee in place and to collect it, however you would collect that fee?

Dr. HAMBURG. Having built a very robust infrastructure to deal with user fees in other components of FDA, I think we can move very quickly and efficiently to establish the user fee collection mechanism. It is important that it is done properly with the right safeguards and firewalls. But we do know how to do that now. We have 20 years of experience on the drug user fee side. So I think the greater challenge is sitting at the table and negotiating to achieve those user fee agreements.

COSMETICS

Senator BLUNT. Do you know what the average fee might be for the various categories of cosmetics producers, medium, small, or large? Do you have a sense of how this impacts the industry?

Dr. HAMBURG. I think we would have to sit down and really talk about the different strategies for approaching it and what would be the most appropriate way to structure the fee system so that there would be the greatest benefit to the industry and it would align with the kinds of demands on our time and resources.

Senator BLUNT. So would that mean you haven't decided yet whether it would just apply to a finished product or have a fee during the entire production chain of cosmetics? I assume they get things——

Dr. HAMBURG. Yes, I think it would very likely be modeled on some of the other fees in terms of registration of establishments. But it is a different regulatory framework than for drugs. For example, where there's a pre-approval process with cosmetics, our legal regulatory responsibilities have to do with monitoring for safety issues and is really not focused on the pre-approval, so it wouldn't follow the exact kind of model of other user fees in existence today.

CHINA

Senator BLUNT. And the China inspection issue, would that be fee-based also, or would you propose some inspections in China?

Dr. HAMBURG. Yes, the China proposal is really to enable us to enhance our inspectional capacity and our presence on the ground in China, as well as to enhance our risk-based analytics and our strategies for our operations in China. But it would be building on existing activities. We'd be expanding our inspectional cadre in China by 16 people and correspondingly increasing the numbers of inspections in both food and drug. But it would not be part of our user fee program.

Senator BLUNT. So it's paid for out of regular taxpayer dollars?

Dr. HAMBURG. Yes.

Senator BLUNT. So these Chinese companies wouldn't pay for their inspection?

Dr. HAMBURG. No.

Senator BLUNT. Obviously, you'd have to agree that their products are going to have to go through this regimen for them to be allowed to come into the country?

Dr. HAMBURG. Right. If we are approving a new drug in this country, we need to inspect to make sure that, if it's being manufactured in another country, that the manufacturing meets our standards and requirements. If we are bringing a food product into this country, we need to inspect the facility to make sure that it's being made according to good manufacturing practice and meets our safety quality standards.

So it would be to enable us to expand work that is under way in China. But you can imagine, based on the huge increase in imports of the FDA-regulated products that I noted, that we are extremely hard-pressed to be able to even begin to do the range of inspections that really are important to assuring safety and quality to the American people.

Senator BLUNT. But under your proposal for food or cosmetics, as an example, either one, that would still be paid out of your taxpayer-funded budget. That's not in the fee proposal, the China inspection?

Dr. HAMBURG. The China inspections are going to be focused on food and drug inspections in China, building on a framework that already exists. We do have offices now in Shanghai, Beijing, and

Guangzhou and are doing inspections out of those offices, and also working with our counterpart regulatory authorities in China and industry that's based in China, either Chinese industries or United States companies, but that are manufacturing in China.

So that $10 million will enable us to expand our capacity in ways that are very, very crucial.

Senator BLUNT. I guess the point that I'm trying to get established for myself is that we would still fund that effort on food, for instance, like we always have, but we would under your proposal have a fee for food inspection for U.S. companies in the United States, which I'd be reluctant to do. But we can visit about that later.

Dr. HAMBURG. What we're trying to do is really create an integrated program that is supported by both budget authority and user fees. In negotiating the user fees, we would be very explicit about how those user fee dollars would be used as part of this broader program. But they would not be siloed programs in terms of impact——

Senator BLUNT. But the user fees wouldn't be paid by the foreign companies. They'd be paid by U.S. companies, unless the foreign companies were producing in the United States?

Dr. HAMBURG. The user fees would be paid by the establishment that was manufacturing a product——

Senator BLUNT. In the United States?

Dr. HAMBURG. No. They could also be if you were manufacturing anything that would be FDA-regulated, foreign or domestic.

Senator BLUNT. So the Chinese company might pay the user fee if it was in China?

Dr. HAMBURG. Yes, yes.

Senator BLUNT. Okay, okay. That's the one point.

Dr. HAMBURG. No, I'm sorry I wasn't clear. But the $10 million we're asking for now is to enhance our ability to inspect the facilities that are manufacturing goods that are FDA-regulated for export into the United States from China.

MENU LABELING

Senator BLUNT. Let me ask a couple of questions about probably the issue that we've gotten the most questions about of anything you're doing this year, which didn't maybe sound all that hard going in, but probably has turned out to be pretty complicated. And that's menu labeling. So if I understand the rule you've got out, on places where restaurant-type food is not the predominant part of the business, this would be certainly grocery stores that might have a food area, one of your options is that they wouldn't be subject to the rule. I think that's option two under your proposed rule. That's how I understand that, that that is one option you believe you have available.

Dr. HAMBURG. Yes. We put forward some draft proposed rule format for comments that included some of the different strategies that could be undertaken. As you note, it has proved very complicated, how you define a restaurant-like establishment and a standard menu. And we have gone out to get comment on the different approaches that could be used for defining the universe of restaurant-like establishments and what should be labeled and how. And we are now in the process of responding to the comments that we've gotten. We got a lot of comments and they covered the waterfront in terms of perspectives on these issues, and we will be coming forward with a final rule in the near future.

Senator BLUNT. As I said in my opening comment, I would certainly be as flexible as you think the law allows you to be here, because there's lots of difficulty, it seems to me, in implementing this, particularly if it's not the principal thing you do, if it truly is arguably incidental to what you do. And the food options vary so much from one of the grocery stores you own to another grocery store you may own because of what's available that day or how the food counters are operated. I would encourage that.

MENU BOARDS

The other two questions that I had that I'd like you to comment on at least, one is the drive-through menu board; what do you think that might entail? And what about places where—I read somewhere in some information I had that Domino's Pizza, that 90 percent of the customers never, never come into a location. So for 90 percent of the customers, they're not going to see what's on the menu board anyway. Is there some understanding that that's a different environment? Do you want them to comply in a different way or do you want them to doubly comply, something on the Web site and something else on a wall that nobody sees? Or what are you thinking there?

Dr. HAMBURG. As I mentioned, we are finalizing the rule that will go forward, so I can't speak to specific details because it's still being discussed and worked through. But in terms of what was sort of put forward in the legislation was the recognition that there were different types of establishments, but how consumers access menus would be the place for communicating the information.

So if you have a storefront, but that isn't where consumers come in to order their pizza, it wouldn't make sense to require a menu board that no one would ever see. But if there's a menu that's on the Internet, that would certainly be an appropriate place, or a flyer that would be distributed, whatever, and the same with drive-through food establishments. Where there is a menu board that you look at to make your decisions, that would probably be the most appropriate place to have the communication as to calorie content of what's on the menu.

But with respect to all of the specifics, it is still in discussion, and we got across the range of different types of establishments a lot of suggestions about different ways to make information available so that it would be most consumer-friendly and-or least burdensome to the industries involved.

Senator BLUNT. My last question is, where I read "nutritional content" does that mean calories or does that mean a lot more than calories, as you comply with this?

Dr. HAMBURG. As I remember, calories was what was clearly indicated for posting with a requirement to indicate that additional nutritional information——

Senator BLUNT. Is available?

Dr. HAMBURG [continuing]. Would be made available on request from the consumer.

Senator BLUNT. Thank you.

Thank you, Mr. Chairman.

Senator KOHL. Senator Brown.

Senator BROWN. Thank you, Mr. Chairman.

KV PHARMACEUTICAL

Thank you, first of all, for your decisive action a year ago on the Makena drug, the progesterone made by KV Pharmaceutical, when they took what was a compound, priced it $10 to $20 per injection, and a woman, a pregnant woman, needed about 20 injections, as you know, in the course of the treatment, and after getting FDA approval jacked the price up to $1,500. Some would say they overreached. Others would say they were greedy.

Your action was important. However, some things have happened that I think demand more attention. As you instructed compounding pharmacies to keep compounding and not to respond to the cease and desist order, it was a real public health victory that you caused. So thank you for that.

Recently, KV Pharmaceutical—and it's pretty incredible behavior, a company that astounds me in its behavior and interaction with its patients—claimed that it collected contaminated samples of the compounded versions of the drug and asked the FDA to investigate. I am pretty amazed how they did it, what they did, but they did. This investigation and the length of it has caused some doctors to be reluctant in prescribing the compound, causing, I would be pretty certain, some women not to get the medication, which means a higher rate, I don't have evidence of that, but I assume—a higher rate of low-birth-weight babies or, second, great expense to insurance companies and taxpayers.

So my question is, what are you doing in this? Are you aware of this slowdown in prescriptions that we're told about, and what are you doing to speed up this investigation so we can put this behind us, so that women who are at high-risk of low-birth-weight babies get access to this drug for $300 or $400 instead, or this progesterone for $300 or $400, instead of—well, they dropped the price from $1,500 to $690. That was really kind of them, so it's only $20,000 instead of $30,000.

What are you doing to fix this public health hazard?

Dr. HAMBURG. When we do get a report, wherever it comes from, of a potential public health concern regarding an activity that we regulate, we take it very seriously and we do follow up. So we are in the process of an inspection, an investigation of the concerns that were raised. Obviously, we need to do this based on more than just reports, especially if the reports come from——

Senator BROWN. The manufacturer.

Dr. HAMBURG [continuing]. The manufacturer.

However, it is an ongoing investigation and I can't really report on details of findings or timing. I have not been made aware of concerns that during this process that there has been a decline in access to the therapeutic intervention overall. And I will go back and look at that.

Senator BROWN. We'll compile what information we can.

Dr. HAMBURG. Okay.

Senator BROWN. Some in the medical community have told us that the number of prescriptions has slowed as a result of the fear that doctors have because this company has made accusations that certainly serve its financial interest. Maybe they're true. I understand you have that responsibility. But you have a responsibility to move as quickly as you can in this case because it's clearly a huge public health threat. Okay, thank you.

IMPORTED DRUGS

Second group of questions. Tainted heparin from China—and I want to follow up on some things that Senator Blunt asked about—in 2008 it killed 100 people in this country, including, I believe—around the world; I'm not sure—including 3 people from Toledo, Ohio. In 2007–2008, melamine was found in pet food and in infant formula in China. I've heard recently, in the last year, from a number of dog owners who lost their animals as a result, their beloved animals, as a result of tainted chicken treats from China.

More recently, the identity and safety of imported fish has become a growing concern, a recurring concern also. You know the importance of this. You've asked for $10 million in your budget, as you pointed out to Senator Blunt and he pointed out, 16 new full-time employees, 7 food safety inspectors, including 7 new safety inspectors and 9 drug safety—7 food, 9 drug safety.

This is a huge problem. There is no way, when you look at—my understanding is it would take the FDA 9 years to perform one inspection at the high-priority pharmaceutical facilities in China and 13 years to inspect all of the foreign-based pharmaceutical manufacturing plants.

Understand $10 million is important. The inspectors are important. But isn't the goal to make the companies that import these drugs—I don't care if they're American companies or if they're French companies or Chinese companies that are selling into the American market. Shouldn't your goal be to make them personally responsible?

I mean, if a chief executive officer (CEO) is not certain where all the ingredients come from, and those ingredients coming from wherever end up killing a patient in Toledo, shouldn't that CEO go to jail? Shouldn't that CEO, that company, be fined huge amounts of money?

We'll never be able to inspect every place in China. What do we do about this? Come up with something more creative than begging the Congress for $10 million so we can sprinkle a few food inspectors and safety and pharmaceutical inspectors in a country of 1.3 billion. Come up with something——

Dr. HAMBURG. I want to reassure you that, number one, this is a huge priority for us and we have a multifaceted program. The $10 million is a small drop in the bucket of what our overall needs are. We do believe that we have to have a strategy that rally increases standards and accountability in the countries of manufacture, that increases the ability for us to work with other regulatory authorities to share information, because many countries are facing the same challenge. We need to really carve up the landscape.

We need to also target our inspectional resources more efficiently so that they can be extended further. And of course, we have to continue our border import safety activities as well, but do it in a more risk-based way.

Senator BROWN. I'm going to interrupt. I'm sorry, Commissioner. Is there any way to do these inspections, short of threatening legal action—and I don't care about, I really don't care about a CEO going to jail or I don't care about a huge fine against the companies. I want these companies to be responsible for their ingredients. Is there any way to do that short of some legal process?

FOREIGN IMPORTER

Dr. HAMBURG. Yes. And in fact, the Congress has helped us in that domain. The Food Safety Modernization Act included a component for foreign importer verification and really puts a requirement on people that are bringing products into this country to verify that they were manufactured in compliance with our standards.

Senator BROWN. And if the ingredients have shown to be contaminated and cost lives, what is the legal resource for a consumer or a family or a country?

ENFORCEMENT

Dr. HAMBURG. I think on the drugs side there's legislation that's currently being considered to give us additional authorities to be able to act and enforce. On the food side, we have been able to achieve more of the tools and authorities that we need. It still is a real problem to take enforcement action proactively in another country, and I think it does speak to the fact that we need to continue to work, as we are, making this a very important area of focus within the FDA, to really——

Senator BROWN. I understand that. But for 100 years in this country, from the creation of the FDA after Upton Sinclair's book, we have worked hard to protect public health and protect food safety and pharmaceutical and drug safety. And just because the company—you don't have jurisdiction in another country doesn't mean that they should have access to our markets unless those companies, the importer or the company, whoever it is that's bringing it in, that they should have ultimate liability for that.

Mr. Chairman, if I could go one other short set of questions. Thank you.

Dr. HAMBURG. I just want to tell you that this is a huge priority, and it's one that we talk about every day in terms of we as a Nation have to really address this. FDA is at the cutting edge of much of this in terms of responding to the challenges of globalization. At the present time, we don't have the tools and authorities that we fully need to achieve that, nor do we have the resources.

Senator BROWN. I respect you. I've watched your career. I'm not convinced yet that you are aggressive enough.

On the question of drug shortages, thank you for your work on that. Thank you for the comments from the chairman.

REPACKAGING

On the issues of repackaging, we sent you a letter about repackaging within a specific hospital. They get 15 vials of drug X, they break it into 5 packages of 3 each to treat a patient, that they're able to repackage and use those, helping to perhaps preclude a drug shortage. I sent you a letter suggesting we do that. We will follow up with some legislative language.

The letter that you sent back to us yesterday was to us inconclusive. I mean, Erin in my office, it wasn't clear to her in reading it that that was a very specific answer. I'd just like to ask you to work with us on the whole repackaging issue, because that can preclude some of these drug shortages.

Dr. HAMBURG. I'd be happy to work with you. I think that actually some of the restrictions have to do with other components of HHS activity, and we need to work——

Senator BROWN. We'll work with you.

Thank you.

Senator KOHL. Thank you, Senator Brown.

Senator Moran.

Senator MORAN. Mr. Chairman, thank you. Thank you to you and to the ranking member.

ANTIBIOTICS—LIVESTOCK

Commissioner, I'm pleased by your presence here today. Recently the FDA-issued guidance concerning antibiotic use by farmers and ranchers in regard to their livestock. Was that guidance based upon peer-reviewed science? The second question is: Would you provide this subcommittee with the science on which that guidance was based?

Dr. HAMBURG. Certainly. We did review an enormous amount of literature over quite a long period of looking at these questions. We also worked very closely with all of the critical stakeholders as we move toward putting forward that guidance, which is to restrict the use of antibiotics for growth promotion and feed enhancement purposes. We actually got a lot of support in both the analytic work for that and in the determination to go forward from our colleagues in animal and veterinary health, and the pharmaceutical manufacturers involved also, I think, believe that the world has changed considerably and we now know a great deal about the impact of injudicious use of antibiotics and the development of antibiotic resistance, that we as a Nation and as a global community are facing a very, very serious public health challenge with respect to antibiotic resistance and that this can make a real difference in order to really reduce this public health threat to both humans and animals with respect to ensuring that we have antibiotics that work.

Senator MORAN. I think you were suggesting that there is broad consensus to back up, in the industry, both the users and the scientific community, to support the guidance that you have issued.

Dr. HAMBURG. Nothing we do ever has consensus, but we did work hard to listen to the concerns of all of the stakeholders and address them.

Senator MORAN. Is it related to the use? When you talk about use for growth, I assume that's as compared to treating disease and infection?

Dr. HAMBURG. Correct.

Senator MORAN. Did the guidance have any implications on that use of antibiotics?

Dr. HAMBURG. Not for treating disease. We do believe that these antibiotics, just as in human populations, antibiotics are used under prescription and guidance of medical professionals, that veterinary professionals should be overseeing the appropriate use for treatment of disease.

Senator MORAN. Commissioner, would you work with my staff to give us——

Dr. HAMBURG. Certainly.

Senator MORAN [continuing]. A summary of the scientific basis for that guidance?

Dr. HAMBURG. Certainly.

[The information follows:]

Questions regarding the use of antimicrobial drugs in food-producing animals have been raised and debated for many years. A variety of recognized international, governmental, and professional organizations have studied the issue. Within the FDA Guidance for Industry No. 209, "The Judicious Use of Medically Important Antimicrobial Drugs in Food-Producing Animals," we have briefly summarized the findings and recommendations from some of the notable reports that have addressed this issue over the past 40 years. These reports provide context to FDA's current thinking on this issue and highlight the longstanding concerns that have been the subject of discussion in the scientific community as a whole.

We acknowledge that a significant body of scientific information exists, including some information that may present equivocal findings or contrary views. However, below is a list of some of the scientific literature that FDA considered in developing this guidance, including some key reports and peer-reviewed literature. This list is not intended to represent an exhaustive summary of the scientific literature but rather to highlight some of the more recent scientific research related to the use of antimicrobial drugs in animal agriculture and the impact of such use on antimicrobial resistance.

—1. 1969 Report of the Joint Committee on the Use of Antibiotics in Animal Husbandry and Veterinary Medicine.
—2. 1970 FDA Task Force Report, "The Use of Antibiotics in Animal Feed."
—3. 1980 National Academy of Sciences Report, "The Effects on Human Health of Subtherapeutic Use of Antimicrobial Drugs in Animal Feeds."
—4. 1984 Seattle-King County Study: "Surveillance of the Flow of Salmonella and Campylobacter in a Community."
—5. 1988 Institute of Medicine (IOM) Report: "Human Health Risks with the Subtherapeutic Use of Penicillin or Tetracyclines in Animal Feed."
—6. 1997 World Health Organization (WHO) Report, "The Medical Impact of Antimicrobial Use in Food Animals." http://whqlibdoc.who.int/hq/1997/WHO__EMC__ZOO__97.4.pdf
—7. 1999 National Research Council (NRC) Report: "The Use of Drugs in Food Animals—Benefits and Risks."
—8. 1999 United States Government Accountability Office (GAO) Report—"Food Safety: The Agricultural Use of Antibiotics and Its Implications for Human Health." http://www.gao.gov/archive/1999/rc99074.pdf
—9. 1999 European Commission Report, "Opinion of the Scientific Steering Committee on Antimicrobial Resistance." http://ec.europa.eu/food/fs/sc/ssc/out50__en.pdf
—10. 2000 World Health Organization (WHO) Expert Consultation: "WHO Global Principles for the Containment of Antimicrobial Resistance in Animals Intended for Food." http://whqlibdoc.who.int/hq/2000/WHO__CDS__CSR__APH__2000.4.pdf
—11. 2003 Report, "Joint FAO/OIE/WHO Expert Workshop on Non-Human Antimicrobial Usage and Antimicrobial Resistance: Scientific assessment." http://www.who.int/foodsafety/publications/micro/en/amr.pdf
—12. 2003 Institute of Medicine (IOM) Report, "Microbial Threats to Health: Emergence, Detection and Response."
—13. 2004 Report, "Second Joint FAO/OIE/WHO Expert Workshop on Non-Human Antimicrobial Usage and Antimicrobial Resistance: Management options." http://www.oie.int/fileadmin/Home/eng/Conferences__Events/docs/pdf/WHO-CDS-CPE-ZFK-2004.8.pdf
—14. 2004 United States Government Accountability Office (GAO) Report—"Antibiotic Resistance: Federal Agencies Need to Better Focus Efforts to Address

Risks to Humans from Antibiotic Use in Animals." http://www.gao.gov/new.items/d04490.pdf

—15. 2005 Codex Alimentarius Commission (Codex), "Code of Practice to Minimize and Contain Antimicrobial Resistance." http://www.codexalimentarius.net/download/standards/10213/CXP__061e.pdf

—16. 2006 Antimicrobial Resistance: Implications for the Food System, Comprehensive Reviews in Food Science and Food Safety, Vol. 5, 2006.

—17. 2009. American Academy of Microbiology. Antibiotic Resistance: An Ecological Perspective on an Old Problem. 1752 N Street, NW, Washington, DC 20036, (http://www.asm.org).

—18. 2011. Tackling antibiotic resistance from a food safety perspective in Europe. World Health Organization (WHO), Regional Office for Europe Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark. http://www.euro.who.int/data/assets/pdf__file/0005/136454/e94889.pdf

—19. 2008. Longitudinal study of antimicrobial resistance among Escherichia coli isolates from integrated multisite cohorts of humans and swine. Alali WQ, Scott HM, Harvey RB, Norby B, Lawhorn DB, Pillai SD. Appl Environ Microbiol. 74(12):3672–81.

—20. 2008. Diversity and distribution of commensal fecal Escherichia coli bacteria in beef cattle administered selected subtherapeutic antimicrobials in a feedlot setting. Sharma R, Munns K, Alexander T, Entz T, Mirzaagha P, Yanke LJ, Mulvey M, Topp E, McAllister T. Appl Environ Microbiol. 74(20):6178–86.

—21. 2008. Effect of subtherapeutic administration of antibiotics on the prevalence of antibiotic-resistant Escherichia coli bacteria in feedlot cattle. Alexander, T.W., L.J. Yanke, E. Topp, M.E. Olson, R.R. Read, D.W. Morck, and T.A. McAllister. Applied and Environmental Microbiology. 74:4405–4416.

—22. 2009. A metagenomic approach for determining prevalence of tetracycline resistance genes in the fecal flora of conventionally raised feedlot steers and feedlot steers raised without antimicrobials. Harvey, R., J. Funk, T.E. Wittum, and A.E. Hoet. American Journal of Veterinary Research. 70:198–202.

—23. 2009. Association between tetracycline consumption and tetracycline resistance in Escherichia coli from healthy Danish slaughter pigs. Vieira, A.R., H. Houe, H.C. Wegener, D.M. Lo Fo Wong, and H.D. Emborg. Foodborne Pathogens and Disease. 6:99–109.

—24. 2009. Associations between reported on-farm antimicrobial use practices and observed antimicrobial resistance in generic fecal Escherichia coli isolated from Alberta finishing swine farms. Varga C., A. Rajic, M.E. McFall, R.J. Reid-Smith, A.E. Deckert, S.L. Checkley, and S.A. McEwen. Preventive Veterinary Medicine. 88:185–192.

—25. 2010. Farm-to-fork characterization of Escherichia coli associated with feedlot cattle with a known history of antimicrobial use. Alexander, T.W., G.D. Inglis, L.J. Yanke, E. Topp, R.R. Read, T. Reuter, and T.A. McAllister. International Journal of Food Microbiology. 137:40–48.

—26. 2011. Lower prevalence of antibiotic-resistant Enterococci on U.S. conventional poultry farms that transitioned to organic practices. Sapkota AR, Hulet RM, Zhang G, McDermott P, Kinney EL, Schwab KJ, Joseph SW. Environ Health Perspect. 119(11):1622–8.

—27. 2011. Association between antimicrobial resistance in Escherichia coli isolates from food animals and blood stream isolates from humans in Europe: an ecological study. Foodborne Pathogens and Disease. Vieira, A.R., P. Collignon, F.M. Aarestrup, S.A. McEwen, R.S. Hendriksen, T. Hald, and H.C. Wegener. 8:1295–1301.

—28. 2011. Distribution and characterization of ampicillin- and tetracycline-resistant Escherichia coli from feedlot cattle fed subtherapeutic antimicrobials. Mirzaagha P, Louie M, Sharma R, Yanke LJ, Topp E, McAllister TA. BMC Microbiol. 19;11:78.

—29. 2012. In-feed antibiotic effects on the swine intestinal microbiome. Looft, T., T.A. Johnson, H.K. Allen, D.O. Bayles, D.P. Alt, R.D. Stedtfeld, W.J. Sul, T.M. Stedtfeld, B. Chai, J.R. Cole, S.A. Hashsham, J.M. Tiedje, and T.B. Stanton. Proceedings of the National Academy of Sciences USA. 109:1691–1696.

In addition, FDA also considered a number of other studies that were referenced by the Department of Health and Human Services in response to the 2004 United States Government Accountability Office (GAO) report entitled, "Antibiotic Resistance: Federal Agencies Need to Better Focus Efforts to Address Risks to Humans from Antibiotic Use in Animals":

—1. Phillips I, Casewell M, Cox T, et al. Does the use of antibiotics in food animals pose a risk to human health? A critical review of published data. J Antimicrob Chemother, 2004;53:28–52.

—2. Holmberg SD, Wells JG, Cohen ML. Animal-to-man transmission of antimicrobial-resistant Salmonella: investigations of U.S. outbreaks, 1971–1983. Science, 1984; 225:833–5.
—3. Holmberg SD, Solomon SL, Blake PA. Health and economic impacts of antimicrobial resistance. Rev Infect Dis, 1987; 9:1065–78.
—4. Lee LA, Puhr ND, Maloney K, et al. Increase in antimicrobial-resistant Salmonella infections in the United States, 1989–1990. J Infect Dis, 1994; 170:128–34.
—5. Varma J, Mølbak K, Rossiter S, et al. Antimicrobial resistance in Salmonella is associated with increased hospitalization; NARMS 1996–2000. International Conference on Emerging Infectious Diseases. March 2002. Atlanta, Georgia.
—6. Varma J, Mølbak K, Rossiter S, et al. Antimicrobial resistance in nontyphoidal Salmonella is associated with increased hospitalization and bloodstream infection—United States, 1996–2000. 51st Annual EIS Conference. April 22–26, 2002. Atlanta, Georgia.
—7. Helms M, Vastrup P, Gerner-Smidt P, Mølbak K. Excess mortality associated with antimicrobial drug-resistant Salmonella Typhimurium. Emerg Infect Dis, 2002; 8:490–5.
—8. Martin L, Fyfe M, Doré K, et al. Increased burden of illness associated with antimicrobial-resistant Salmonella enterica serotype Typhimurium infections. J Infect Dis, 2004; 189:377–84.
—9. Smith KE, Besser JM, Hedberg CW, et al. Quinolone-resistant Campylobacter jejuni infections in Minnesota, 1992–1998. N Engl J Med, 1999; 340:1525–32.
—10. Neimann J, Mølbak K, Engberg J, et al. Longer duration of illness among Campylobacter patients treated with fluoroquinolones. 11th International Workshop on Campylobacter, Helicobacter, and Related Organisms, 1–5 September, 2001. Freiburg, Germany.
—11. Nelson JM, Smith KE, Vugia DJ, et al. Prolonged diarrhea due to ciprofloxacin-resistant Campylobacter infections. J Infect Dis, 2004; in press.

Senator MORAN. Thank you very much.

NUTRITION LABELING

Let me express my concern—and Senator Blunt raised this topic, but the nutrition labeling of standard menu items at chain restaurant provisions was authorized by the Patient Protection Affordable Care Act. It's my view that that law was intended to provide a uniform standard for chain restaurants with 20 or more locations to comply with various State and local menu labeling laws.

The concern I want to express is that the expansion of that—those regulations, to grocery stores is in my view a serious problem. In fact, the Office of Management and Budget (OMB) determined that this was the third most burdensome regulatory implementation of any law. Of any law that's currently being implemented, OMB says this is the third-largest regulatory burden. They estimated an increase of over 14.5 million hours of work and almost $70 million for increased recordkeeping costs alone.

I would just encourage you strongly and insist to the degree that I can that you not take this opportunity to regulate further than is required by the law. In part, I would express my concern, certainly about the cost that is occurring or will occur to the grocery store businesses. For many members of Congress, I assume that's a large chain. We have a bit of that in Kansas, but many of our grocery stores are very small. They are marginal. We struggle—in fact, I remember numerous times in my time as a House member, now as a Senator, telling people that where I come from economic development can be whether or not there's a grocery store in town. It's a very basic need.

In fact, I'm a co-chair of the Senate Hunger Caucus. We're working with colleagues here in the Senate, but with the U.S. Department of Agriculture (USDA), in regard to so-called food deserts, where grocery stores are not available. It's often the core center of cities, often rural communities. The ability for a grocery store to survive is very difficult now, and the burdens that you may place upon grocery stores will exacerbate the problem of access to high-quality foods, including fruits and vegetables.

I didn't see in what I read about FDA's cost analysis that there were very many benefits as far as calorie intake or health of the consumer related to the additional regulation of grocery stores in regard to so-called menu labeling. I want to point out the significant increase in cost, but I also want to point out these regulations may significantly damage the ability of everyday Americans who live in places that are already difficult to access quality food—it may reduce the access to that quality food even further.

Dr. HAMBURG. I appreciate your comments, but I just want to make clear that the law did indicate restaurants and restaurant-like establishments. That was not intended, obviously, to address every single grocery store. But the challenge has been trying to determine—there are big grocery stores that have restaurant-like cafés with a menu and prepared food. So that's a very different thing than looking at menu labeling of everything that would be sold in a grocery store, whatever.

So I just want to make clear that I think that the universe that would apply to a grocery store is much smaller than perhaps you have understood. We have put out for comment various potential strategies for how you would define a restaurant-like establishment, and of course the issue of how to deal with grocery store cafés and these kinds of prepared foods for immediate consumption. That's been one of the huge areas of complexity and where we're still trying to sort out what does make sense in terms of benefits to consumers, but not being overly burdensome, and having it really be implementable.

So I take very seriously what you say.

Senator MORAN. Commissioner, thank you. Even if it is a larger grocery store, I assume the kinds of things that may get picked up are salad bars and fruit stands. Fruits and vegetables are a significant component of increasing the healthiness of the American consumer. Let's make certain that in the quest to further regulate we don't actually diminish the opportunities for—I can see the circumstance in which a grocery store, if you pursue these regulations, simply decides: We're no longer going to provide the salad bar or the opportunity for fresh fruit; it's just not worth trying to comply with these regulations that FDA is pursuing.

Finally, Mr. Chairman, I would just express concern about the fees that you're talking about. Mr. Blunt—my time has expired, but the ranking member raised this topic. Those are significant increases in cost of doing business, that in this economic time can be very damaging to the ability of a business to stay in business.

Thank you, Mr. Chairman.

Senator KOHL. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

Thank you for being here today, Commissioner. It's always good to see you. I want to start with a quick observation, that's going to take some follow-up because I don't have all my facts today. I was in Arkansas over this most recent recess, and I talked to a pharmacist. She told me that one of the games that the pharmaceutical companies are playing right now allow a company to take an old drug that's been around forever and somehow gain exclusively to sell the drug.

But nonetheless, the cost has gone up considerably and it's the same old drug. So I'd love to sit down with you or your team and talk about that.

FACILITIES

Let me ask you about your budget, and specifically about buildings and facilities. I know that we're on a spending decline for most agencies. In fiscal year 2011, as I understand it, for your building and facilities fund you had $12.75 million; fiscal year 2012, $8.7 million; fiscal year 2013, $5.3 million. So you're really shaving down the building and facilities account.

That concerns me because you do very valuable, very important work. I know this isn't the budget, if you had a magic wand that you would choose. But we are where we are.

Do you share that concern that I have, that you may not have enough money for facilities?

Dr. HAMBURG. I do. As you know, this is a budget of very hard choices. And it's discouraging in such critical areas as building and facilities, as well as other arenas, to see limitations on dollars that are needed to make a difference. It will mean that we'll have to defer some maintenance activities, some upgrade activities. It means we're going to have to really prioritize to address those buildings and facilities issues that are most critical to supporting our mission in terms of being able to review and approve products and do the research necessary to support those efforts and to make sure that we have the safety systems in our laboratories, for example, that are necessary for our employees.

NATIONAL CENTER FOR TOXICOLOGY RESEARCH

It is a huge concern, I'm sure you recognize, that the National Center for Toxicology Research (NCTR) in Arkansas is a place that we have a very important and unique lab resource, and this is a reduction that will come very hard on them. But we will work carefully with them to make appropriate decisions.

I should note that 2011 was really a high water mark in our buildings and facilities budget. It's not as though we have been at a steady state. We have always been stretched very thin, and I think it is reflected, unfortunately, in our inability to maintain all of our facilities at the levels that we would like.

NANO

Senator PRYOR. You mentioned NCTR and I know that you're very familiar with the work they do down there. One type of work is this new and emerging nano research. I would hate to see that slowed down or stopped based on the facilities, because they're obviously going to need space and infrastructure to have the ability to do this work.

They have plenty of room out there to do it. It's just a question if they have appropriate space within their existing facilities or if they need to reconfigure the space. But I hope, as you're going through this year and managing the agency, you will always remember them and try to continue on with that mission.

Let me move on to the next topic, which is again back on NCTR. I know you came down there. Was that last year, I guess?

Dr. HAMBURG. I've been there a couple times, but I was most recently there in August of last year.

Senator PRYOR. August of last year.

Dr. HAMBURG. It was hot.

Senator PRYOR. Yes, it was. I remember that. Thank you for coming down again.

We're trying to establish this virtual center of excellence in regulatory science. I'm curious about an update on that. As you know, that's a multi-partner thing that they're trying to pull together.

Dr. HAMBURG. Yes.

Senator PRYOR. So where are we on that?

NATIONAL CENTER FOR TOXICOLOGICAL RESEARCH COLLABORATION

Dr. HAMBURG. It's an exciting collaboration. It involves the State of Arkansas, the five research universities in Arkansas, and the FDA through the National Center for Toxicological Research. There are a number of things that are under way or about to happen. One is that there will be a regulatory science credentialed program, training program, at the University of Arkansas in their school of public health. The first class will begin in the fall, and that will be very, very important in terms of helping to ensure that we have the cadre of trained professionals that we need going forward, whether they work in academia, industry, or government. We need those people for the future.

The State of Arkansas will be helping to support stipends for students in that program and we'll be helping with teaching and developing the curriculum.

We also have a research agenda focused in the nanotechnology area, and that is producing some exciting projects and collaborations really looking at issues at the present time of characterization and toxicology with respect to nano materials and nanotechnology processes.

Senator PRYOR. That's great. I think that is truly a partnership, a collaboration of lots of different entities. You guys are obviously very critical to that. But Arkansas's pitching in a lot, too. Thank you for your leadership on that.

Now, I have another question, since we've been talking about nanotechnology here, in 2007 there was a nanotechnology task force report. Here we are 5 years later. I'm wondering if that needs to be updated. Also, do you have a state of nano regulation, so to speak? How's the process going of trying to get your hands around nanotechnology?

Dr. HAMBURG. The work of that task force is ongoing and there is measurable progress in some critical areas, some of it reflected in what we were just discussing in terms of ongoing research and training activities. Also, FDA has been working with industry in the areas that we regulate where nanotechnology or nano materials are now being used.

We're actually about to issue a couple of new guidances, I believe any day now, that will be I think very helpful to the food industry and cosmetics with respect to their use of nano materials and nanotechnology.

We are dealing with nanotechnology as we deal with other emerging technologies where we have an important responsibility to help to advance the opportunities that are part of these new technologies, but also to really study and ensure safety short-term and long-term in terms of the use. We are seeing the application of nano-related techniques and materials across many domains of FDA activity—drugs, devices, food, cosmetics. So it's an area that is very, very active at the present time.

Senator PRYOR. And you think that the FDA has its arms around the direction nano is taking here and the resources to take care of that?

Dr. HAMBURG. I think that we do. I think that the opportunity to engage in public-private collaborations is very, very critical so that we can assure access to the best and the brightest minds, wherever they are, in terms of the research that needs to be done, and then working closely with industry to address both the potential uses and the opportunity to really understand and identify any potential concerns in relation to that, so that we can look at both the ability to deliver innovative new products and strategies, but also assure safety.

Senator PRYOR. Thank you, Mr. Chairman.

Senator KOHL. Thank you, Senator Pryor.

Senator Collins.

Senator COLLINS. Thank you very much, Mr. Chairman.

DRUG SHORTAGES

Dr. Hamburg, physicians, pharmacists, and patients throughout this country are continuing to struggle with alarming shortages of certain vital drugs. I've heard about this from virtually every hospital in my State. Many of the drugs in short supply are truly vital. They're used for chemotherapy, for example, or for anesthesia or for the treatment of infections.

There are also shortages of drugs used in emergency rooms and intensive care units. Eighty percent of hospitals are reporting that they've had to delay treatment due to shortages. That is so troubling to me, and it's why I've joined with Senator Amy Klobuchar of Minnesota in introducing a bill to require pharmaceutical manufacturers to report to the FDA whenever they see evidence that they're going to have a shortage of a drug, whether it's because of raw material shortages or contamination, whatever the reason.

Now, this builds on the model of a drug shortage program that already exists in FDA, but it is a voluntary program for manufacturers. Nevertheless, it's my understanding that FDA, acting on these voluntary reports, has been able to avert almost 200 shortages in the last year.

There's been a tripling of the funding for the drug shortage program and yet we still see these shortages of critical drugs. So could you first give me some insight as to why these shortages are persisting, what FDA thinks should be done, and whether or not you have the resources and authority that you need?

Dr. HAMBURG. Thank you and we appreciate your leadership and work on the drug shortage issue. It's a huge concern, of course, to our country. As you identify, it cuts across many important areas of medical care.

In recent years we have seen the numbers of drug shortages going up, although there was a report—I saw it in the Washington Post—that the University of Utah, which tracks drug shortages, is actually reporting that the numbers so far this year are one-half what we saw in the same timeframe last year. So that is encouraging.

But drug shortages are occurring for a number of different reasons, complex reasons, that have to do with the nature of the drugs in short supply. The majority of the drugs that are in shortage are sterile injectables that present very specific manufacturing issues and also often are older drugs and generic drugs with a limited number of manufacturers.

There also are economic forces at play, and I think we need to continue to work to fully understand the factors that are causing the drug shortages, so as a Nation we can best address those.

With respect to the FDA role, we can't stop the shortages from happening. We can't compel manufacturers to make drugs if they choose to discontinue. We cannot assure that all of the precursor materials will be available or that the manufacturing will meet the quality standards that the American public expect and demand.

But what we can do, and as the proposed legislation really addresses, is respond quickly and with a lot of flexibility when we have early warning that a shortage may occur and a disruption in the supply chain. That's how we were able to prevent, as you noted, almost 200 drug shortages last year and about 30 so far this calendar year.

We did put out a request at the end of October to drug manufacturers to voluntarily report to us if they saw a potential shortage situation looming. Since that time we've gotten a sixfold increase in reports and that has been very, very helpful. But we think that there is real value in making it more explicit through legislation and really enabling us to systematize the information that we get, and I think that will help us to also establish the kind of databases that we need to be able to track more effectively and learn from the shortages.

But we have, using our ability to work with manufacturers to address quality issues, our ability to work with manufacturers who aren't facing quality issues or distribution issues but make the same drug, to increase their manufacture to address the shortage problem, to bring a new manufacturer on board in some instances, and sometimes to look overseas if there's a drug that can address the shortage need and make sure that that drug meets our standards of safety and efficacy, but for targeted use bring it over.

So we do have tools when we know about a shortage situation or a looming shortage, and we look forward to working with you.

Senator COLLINS. And of course, if you're able to notify healthcare providers that a shortage is upcoming, they may be able to substitute a drug without interrupting treatment halfway through.

Dr. HAMBURG. Right, and we can work with them on that, and we do.

ARTIFICIAL PANCREAS

Senator COLLINS. There is, very quickly, another issue I want to raise. I'm the co-chair and the founder of the Senate Diabetes Caucus, and I'm very excited about the potential for an artificial pancreas. I know that it would have the impact of dramatically improving the health and quality of life for individuals living with diabetes, particularly type 1 diabetes.

The FDA has moved forward, has issued draft guidance—I was encouraged that that happened last December—to move to clinical trials from an inpatient to an outpatient basis. It's my understanding that the first outpatient trial using an artificial pancreas will be held at the University of Virginia. So I commend you for that.

I know there's been a lot of comments on the draft guidance by the Juvenile Diabetes Research Foundation (JDRF) and other stakeholders, and I hope you'll look at those comments.

What I want from you today is a timetable. Could you tell us when you plan to finalize the draft guidance on the artificial pancreas, and also the draft guidance on the low glucose suspend system, which is available in other countries, and thus it's been a source of frustration to a lot of people living with diabetes that it's not available here?

Dr. HAMBURG. Both of these guidances represent very important advances, as you know. If we could get an artificial pancreas on the market, it would make a huge difference in the lives of so many patients living with diabetes and their families. It is something that we're very excited about the opportunity that advances in science and technology now offer. We want to do our part in making sure that we can advance this as quickly as possible, but mindful that this is a very sensitive kind of a medical device and you want it to work properly or else it doesn't benefit anyone.

I can't give you an exact timeframe. We are actively looking at comments and we have been working very intensively and closely with organizations like JDRF and healthcare providers in this area. We very much want to move it forward swiftly and we think that there's a lot of alignment in terms of the strategies, and we've gotten a lot of input in terms of the strategies for moving, as you point out, quickly to the clinical assessment and moving from a more controlled hospital environment to the more real world outpatient. But we want to do it right, but we want to do it in a way that's mindful of the fact that time matters to people who are living with diabetes type 1.

Senator COLLINS. I do hope that you'll be able to finalize the guidance this summer. I know that's the hope of many of the advocacy organizations and physicians and other experts in this field.

I thank you, Mr. Chairman, ranking member, for your patience.

Senator KOHL. Thank you, Senator Collins.

PREMARKET APPROVAL

Dr. Hamburg, in your statement, you spoke about improving the premarket approval process for medical devices, which is important to get the best medical care to patients. I and others have been concerned about the postmarket surveillance of medical devices and introduced bipartisan legislation to improve the surveillance. As you know, recent news reports have highlighted postmarket problems with medical devices, such as hip implants and most recently heart wires.

Given these reports of serious medical device failures, don't you agree that your current tools and strategies for postmarket safety, nearly all of which are voluntary, are in need of improvement?

It's my understanding that FDA is working on a new comprehensive postmarket surveillance strategy and is planning to unveil it shortly.

Dr. HAMBURG. This is correct.

Senator KOHL. Could you give us some indication and some elaboration on what you're planning to do?

Dr. HAMBURG. There are a number of different ways that we have to address the issues of ongoing monitoring of safety and efficacy once a product is in the marketplace. We are putting forward a strategy to strengthen postmarket surveillance and to really build on data that is available in terms of electronic health records and information that is already being collected, but that we can tap into to strengthen our ongoing monitoring.

We also have, as you probably know, introduced in some of these higher risk areas requirements, working with the manufacturer, for ongoing targeted data collection as to safety in the experience with these products once they are in use and once we have the opportunity to really understand more about how they're really working in the medical care context and in the context of daily lives.

We also are eager to—in some key areas this has already been begun—create some registries that will enable us to have a deeper knowledge and understanding about the experience with these products, and we also believe that fairly soon we'll be able to implement the unique device identifier, which will again create an infrastructure for better monitoring of devices in the postmarket setting.

So there's a lot of different strategies under way that get to the heart of your question, which is the concern for oversight of the lifecycle of these products and the ability to respond quickly to emerging public safety issues.

INFORMATION TECHNOLOGY

Senator KOHL. All right. Secretary Hamburg, the budget request offsets some of your proposed increases through a decrease of $8 million in IT and administrative savings. As we know, budgets are not increasing, so we all have to work smarter. An obvious way to do that is to eliminate redundant or wasteful programs. Which are some of the programs you've found to be in that category and does your budget request deal with some of those programs? If so, tell us about those programs?

Dr. HAMBURG. Yes. In the area of IT we are going to be able to find some meaningful cost savings through activities to both consolidate our systems into a data center and have savings in terms of efficiencies and reductions in contract costs. As well, we're moving towards a system that will enable us to avoid duplication in terms of laptops and other IT equipment, and that actually is going to produce a surprisingly large amount of savings.

Then through other IT initiatives, retiring old legacy systems and really looking at our business processes and a number of other actions being taken, we will be able, I think, to meet our targeted reduction of, I think it's $19.7 million, in the fiscal year 2013 budget.

I have to say, and embarrass him because he's here, we have a wonderful new chief information officer (CIO), Eric Perakslis, who is really bringing a whole new way of thinking and doing business to FDA, strengthening both our IT systems and also enabling us, I think, to really deepen and strengthen our scientific computing, which will make such a difference in our ability to really address critical issues of safety, efficacy, and quality of the products that we regulate.

Senator KOHL. Okay, Dr. Hamburg.

Senator Blunt.

Senator BLUNT. Thank you, Mr. Chairman. I just have a couple more questions.

Actually, since we're talking about IT, let's just go ahead and go there. That was one of the areas I wanted to visit with a little bit. The Government Accountability Office (GAO) report wasn't very good and do you want to talk a little more about how the new CIO is responding to that and how you feel about it? Information technology is about 10 percent of the money you're spending and GAO just frankly said they didn't think you were spending it very well.

Dr. HAMBURG. I think that they will have a different message soon. That certainly is my hope and my commitment. They looked at a period that was time-limited and doesn't, I think, reflect many of the advances that have been made and that are continuing to be made. They address a number of issues about our application list, which in fact we are in a very different place now. And while that will always be a dynamic listing because we want people to be introducing new applications and trying new things, we feel that we now have the kind of list that GAO is looking for and we'll be able to sit down and talk with them about it.

They talked about—the bulk of our money is really being spent on a limited number of really major systems, and it is very, very important that we examine those systems to make sure that they are working, that we really need them. We're transiting to other ways of doing business that will in fact be both more effective and more efficient.

They talked about that we didn't have a strategy. We have a strategy that again is in its final stages. He's been working hard since he's been with us. He came on board at the end of October.

INFORMATION TECHNOLOGY PROGRESS

But we have made enormous progress and, while I think it was a little discouraging to see their report because we know it doesn't reflect all the progress that has been made, the good news is that that progress has in fact been made. It is very much in correspondence with the kinds of recommendations that GAO put forward in their report, and it is my strong belief that they will be pleased to see the progress made, and I hope that you will be pleased to see the progress made.

Senator BLUNT. Have you been in a position to replace some of your old systems? Is that one of the things you're evaluating, whether there is a much cheaper alternative to the old systems you had?

Dr. HAMBURG. Yes, definitely. Consolidation of systems and using new strategies. I'm not an IT person, I will admit, but moving to cloud computing and other things changes the landscape dramatically.

LIFE SCIENCES-BIODEFENSE LABORATORY

Senator BLUNT. The other thing I wanted to talk about, you had a request here to move into the new building. Where will this request get you if we're able to get to most of that?

Dr. HAMBURG. This request will enable us to actually go in and use this laboratory space to do absolutely critical work in the drug and medical countermeasures arena in particular. We have a building that has been basically built out by the General Services Administration (GSA), but in order to occupy it with laboratories that meet safety codes and other things we do need those additional dollars. It would be a tragedy, I think, to have invested so much in building this new, critically needed and unique facility, and then not be able to actually utilize it.

Senator BLUNT. And that amount for outfitting that building, does somebody have a number there?

Dr. HAMBURG. $17.7 million.

Senator BLUNT. A little over $17 million.

MEDICAL COUNTERMEASURES

You mentioned medical countermeasures and that was the last thing I was going to ask about. Talk to me a little about that, and talk to me about what you are doing or you believe you could do, or we could help you do, with like the Department of Defense (DOD), that clearly has done a whole lot of work in this area. A lot of what they've done could serve a bigger population, and maybe is. I'm asking for information here.

Dr. HAMBURG. The medical countermeasures is obviously a critical area in terms of health, safety, and security of our Nation. It involves our ability to have the medical tools, the diagnostics, the drugs, the devices, and other technologies to enable us to respond to a set of naturally and deliberately caused threats, whether it's pandemic flu or a nuclear, radiological, chemical, or biological attack, but the kinds of threats that could really be catastrophic in their implications for health and stability in our country.

We do work closely with DOD and other components of government in terms of our activities. But we are a critical link in the chain. Whether it's a product for DOD or a product for civilian use, FDA standards review and approval is necessary for use. Through this program, which has sort of three main pillars—one is to make sure that we have the best possible review systems for dealing with these often complex products, that we have the underlying science to enable us to deal with these products, and that we have really the updated legal and regulatory framework for dealing with medical countermeasures.

In all these areas there are complexities that may not exist in other domains, because sometimes you're talking about a disease that actually doesn't occur naturally in nature and where you can't possibly expose people to see if your drug or your diagnostic works and there may not be an animal model. So we have to be very flexible in our regulatory pathways. We have to develop new science, whether it's the appropriate models or innovative clinical trial strategies, to really ask and answer important questions about safety and efficacy, and then of course working with the companies that might be developing some of these new products. Because of an increased level of scientific and regulatory uncertainty, our ability to work closely with them really matters.

So this program is very, very important. I think that's recognized by all of our partners in government and outside. We have really been trying to work closely with the DHS and DOD to really identify what are the critical threats, what are the gaps in terms of available products, and what's needed to address those.

In this budget request for fiscal year 2013, one of the areas of critical focus is in fact on the warfighter and the need for additional products in some key areas that have to do with trauma sustained in the battlefield, and also the potential threat of chemical, biological, radiologic, and nuclear exposures.

Senator BLUNT. Very good.

Mr. Chairman, I think that's all I have for today.

Senator KOHL. Thank you very much, Senator Blunt.

We'd like to thank you, Dr. Hamburg, for being with us today.

ADDITIONAL COMMITTEE QUESTIONS

Members of the subcommittee can submit questions in a week's time, by Thursday, April 26, and we'd appreciate your response within 1 month of our submitting those questions to you.

Dr. HAMBURG. We certainly will.

Senator KOHL. Thank you so much.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO DR. MARGARET HAMBURG

QUESTIONS SUBMITTED BY SENATOR HERB KOHL

FOOD SAFETY

Question. Dr. Hamburg, this budget request assumes $220 million in additional funding that theoretically would be used to implement the Food Safety and Modernization Act. However, that funding increase would come in the form of a new user fee that has already been rejected by the Congress and that essentially has no chance of being authorized this year. So what that really means is that this budget doesn't include any funding increase to implement the Food Safety and Modernization Act, which is of great concern to me.

If this new user fee isn't authorized, and at this point it appears it won't be, what does that mean for FDA's ability to implement the food safety law? What won't happen?

Answer. The FDA Food Safety Modernization Act (FSMA) envisions a modern new food safety system that is prevention-oriented, science- and risk-based, and efficient.

However, it cannot be fully realized without the proposed fiscal year 2013 resources. If FDA does not receive the additional resources recommended in the fiscal year 2013 budget, then implementing FSMA will be significantly delayed or limited in several priority areas. Specifically, in the absence of the funding proposed for fiscal year 2013, FDA must delay its implementation of preventive controls because it will have limited capacity to develop guidance, conduct outreach and provide science-based technical assistance to industry, and retrain FDA and State inspection forces. FDA will also experience delays in its ability to create the new import oversight system required by FSMA and fulfill the FSMA vision of an effective, credible food safety system that uses the best modern tools to prevent food safety problems.

Question. Assuming we are working under the same budget restraints as you are, please send us information shortly on what the highest priority activities are that would have been funded with the user fees.

Answer. Priority FDA activities for implementing the FDA Food Safety Modernization Act would include continuing to focus on rulemaking to implement FSMA. FDA would also prioritize funding for the national integrated food safety system in the form of State grants, contracts, or cooperative agreements with regulatory and public health partners to improve, strengthen, and standardize regulatory activities among all partners as mandated by FSMA. As FDA enhances its risk-based decisionmaking efforts, another priority area for FDA is improving knowledge management tools for risk analysis, such as iRisk and iPrioritize, and investing in innovative information technology that will provide a systematic and transparent approach to identify, characterize, and evaluate food safety risks throughout the food supply system and to evaluate the potential impact of control measures or intervention strategies. Finally, FDA will further expand planning and response tools and systems to collect information for surveillance and outbreak detection, from traceback, and for post-response activities. This effort will allow FDA to identify trends and improve the effectiveness of future response and prevention activities.

MEDICAL COUNTERMEASURES

Question. The budget request includes a small increase of $3.5 million for your Medical Countermeasures Initiative, which helps FDA work to develop drugs, vaccines, diagnostics, and other medical products needed to respond to chemical, biological, and other threats and emerging infectious diseases. Congress provided $20 million last year for this initiative.

Can you talk about what you have accomplished so far, and what you plan to do this year?

Answer. We have made significant progress in implementing FDA's Medical Countermeasures Initiative (MCMi). Key accomplishments include establishing action teams to identify and help resolve challenges to developing multiplex diagnostic tests and medical countermeasures (MCMs) for acute radiation syndrome, warfighter-trauma care, and at-risk populations such as children and pregnant women. We have also established an action team to develop strategies to assess MCM safety and performance during public health emergencies.

FDA held workshops on developing and evaluating next-generation smallpox vaccines, regulating multiplex diagnostic tests, and ethical and regulatory challenges for MCMs in pediatric populations. FDA also held advisory committee meetings on smallpox drugs, MCMs for pneumonic plague, and antimicrobial medkits. These efforts have assisted us in establishing clear regulatory pathways for a next-generation smallpox vaccine, smallpox drugs, and multiplex diagnostic tests.

Additionally, FDA finalized a pre-emergency use authorization package for an acute radiation syndrome MCM that is in strategic national stockpile, which will help enable rapid distribution in a radiological or nuclear event. FDA also launched a rigorous MCM regulatory science program, a program to qualify animal models, and a multifaceted MCMi professional development program.

Our fiscal year 2012 MCMi priorities include sustaining FDA action teams and the MCM regulatory science program, with a focus on critical regulatory gaps and emerging technologies. We plan to strengthen our MCM regulatory science partnerships with academia and U.S. Government partners. And we plan to identify and communicate best review practices for MCMs across FDA and to re-issue draft guidance on addressing efficacy under the Animal Rule.

FDA will also be holding workshops on developing animal models of pregnancy for MCM development and on radiation biodosimetry. FDA also plans to enhance pre-event planning and our process for rapid deployment of MCMs. Finally, FDA will continue our professional development program and expand our outreach activities.

Question. With resources becoming more limited every year, but the need for this work continuing as threats evolve and change, how do you prioritize to ensure that you're using the money in the most effective way?

Answer. FDA is working very closely with our U.S. Government partners through the Department of Health and Human Services' interagency Public Health Emergency Medical Countermeasures Enterprise (Enterprise) to build and sustain the civilian MCM programs necessary to respond to public health emergencies. FDA is fully engaged with our enterprise partners at all levels to help develop and stay abreast of near-, mid-, and long-term MCM priorities and requirements and to ensure that our activities and investments are aligned with Enterprise goals and priorities, which are driven by threat and risk assessments. For example, FDA subject matter experts and senior leadership participate in the various Enterprise partner committees and working groups that develop MCM requirements, plans, priorities, and policies and that conduct program oversight and integration.

FDA has also engaged Enterprise partners in implementing our Medical Countermeasures Initiative (MCMi) to ensure appropriate alignment with Enterprise priorities. For example, we have established a steering committee comprised of Enterprise partners to peer review research proposals for our MCM regulatory science program. This steering committee ensures that the regulatory science research that we fund is in alignment with Enterprise MCM priorities and focused on critical gaps or important emerging technologies.

We also regularly meet with senior leadership at the Department of Defense to coordinate MCM activities and to ensure that our investments are appropriately aligned to Department of Defense MCM priorities and goals.

CHINA IMPORT INITIATIVE

Question. The budget request includes $10 million to increase FDA's inspection capabilities in China, as well as work with the Chinese regulators and industry on maintaining U.S. quality and safety standards. You noted previously that the number of shipments of FDA-regulated products from China increased by 62 percent from 2007 to 2011, so the emphasis there is understandable.

Is the FDA working alone on this, or is this part of a larger Government initiative?

Answer. With reference to increased FDA staffing in China, FDA is working with Chinese regulators and the U.S. Department of State. On the broader topic of imported commodities originating from China, FDA continues to work with other U.S. Federal agencies, including the U.S. Departments of Agriculture, Homeland Security, and Commerce, the Office of the U.S. Trade Representative, other agencies within the U.S. Department of Health and Human Services, as well as other Federal counterparts, with U.S. State regulatory agencies and with other foreign regulatory counterparts. As part of a comprehensive strategy to strengthen trade enforcement and enhance trade related inspections, the fiscal year 2013 budget includes an additional $10 million to expand FDA's presence in China and ensure the safety of imports before they enter the United States. As growth in imports of FDA-regulated products continues to increase, and such products travel through increasingly complex supply chains, FDA continues to leverage relationships with relevant stakeholders to fulfill our mission to protect the health of American consumers.

Question. The proposal would add 16 additional inspectors based in China, and three analysts based in the United States. That averages out to over half a million dollars for each additional person—that is a lot of money, so you must have additional plans for these funds.

How else will this $10 million be used? Specifically, how do you plan to enhance Chinese understanding of U.S. standards besides hiring additional inspectors?

Answer. While the vast majority of work done by new proposed staff will be in the area of inspections, FDA will use some funding for workshops, conferences, and strategic seminars that will further our efforts to ensure that Chinese manufacturers comply with relevant FDA requirements for safety and quality. The new staff will work to expand FDA's capacity-building efforts to strengthen China's regulatory capacity and will provide the information, tools, and training that will enhance the safety of FDA-regulated products exported from China to the United States.

FDA's primary goal of increasing staff in China is to enhance compliance with relevant FDA regulations and requirements for FDA-regulated goods exported from China. Inspections can drive increased compliance, as can strategically targeted training and capacity building. Often, these activities complement one another. In China, we have used information from investigations performed by in-country inspectors to undergird and inform our strategy for capacity-building. The overarching goal of these training activities is to encourage Chinese manufacturers to implement measures to ensure that their products meet FDA requirements.

Question. Is this a scalable initiative?

Answer. The fiscal year 2013 China Initiative contains additional positions to meet FDA's expanding workload in China. We hope that the following background will highlight how FDA has already been scaling up activities in China.

Each year since opening our China Office, FDA has set year-on-year records for numbers of FDA inspections in China. In fiscal year 2008, FDA performed 87 inspections in China. By fiscal year 2011, that number had grown to 245. Since 2009, two food investigators and two medical products investigators have served within FDA's China Office. These staff has helped FDA achieve these significant increases in inspection numbers. Our inspections abroad will continue to increase under the requirements of the Food Safety Modernization Act and the Food and Drug Administration Reform Act.

Question. What work, if any, have you done with the Chinese Government in preparation for this initiative?

Answer. FDA has initiated discussions with the Chinese Government and the U.S. Department of State to seek approval for this increase in FDA staffing in China. The FDA Commissioner has also informed her regulatory counterparts in China through written correspondence of FDA's interest in expanding its inspection presence in China. The staff that established the FDA China Office in 2008 included four investigators. This cadre's work has provided Chinese regulators with ample evidence of both the seriousness with which FDA regards its mission to protect U.S. public health and of the mutual benefit that the presence of FDA inspectors in China can bring.

DRUG SHORTAGES

Question. Dr. Hamburg, we have all been reading in the news recently about the large number of drug shortages, often for critical diseases such as cancer and heart disease. In your statement you note that in 2011, FDA prevented at least 195 drug shortages. This is impressive, but still the number of shortages continues to grow. In fact, they tripled from 2005 to 2010, and reached record levels in 2011. Recently, legislation has been introduced that would require drug companies to notify FDA of impending shortages so your agency can begin to take action sooner.

Understanding this is a complicated issue, can you speak to what you believe are some of the underlying causes of this increase in shortages?

Answer. In 2010, there were 178 drug shortages reported to FDA, 132 of which involved sterile injectable drugs. In 2011, FDA continued to see an increasing number of shortages, especially those involving older sterile injectable drugs. Two hundred and fifty-one shortages were recorded for 2011, and 183 of these involved sterile injectable drugs. These shortages include cancer drugs, anesthetics used for patients undergoing surgery, drugs needed for emergency medicine, and electrolytes needed for patients on IV feeding.

A number of different factors contribute to the shortage of sterile injectables and other drugs, including manufacturing issues and economic factors. Some companies have decided to discontinue making their products for business reasons, others have had problems with their raw material suppliers, and some have shown manufacturing deficiencies that compromise the safety and efficacy of their products. Even when there is more than one firm making a drug, there is limited manufacturing capacity for sterile injectables at each manufacturer. When one firm has a delay or other problem, it is difficult for the remaining firms making the drug to increase production quickly to avoid or address a shortage.

FDA works to find ways to mitigate drugs shortages. However, there are a number of factors that can cause or contribute to drugs shortages that are outside of FDA's control. Also, FDA has no legal authority to compel drug manufacturers to manufacture or continue to manufacture a drug.

Question. In what ways could we be of assistance to you as you try to deal with this issue? Are there additional tools that you could use?

Answer. Early notification from manufacturers to FDA can help prevent drug shortages in certain circumstances. With earlier notification, FDA may be able, for example, to work with the company on the issues causing the shortage before the supply is depleted and may be able to contact other manufacturers of the drug to encourage them to increase production.

FDA is doing everything it can, within the agency's authority, to mitigate and manage shortages as they occur. However, many drug shortages arise from quality or other issues experienced during the manufacturing process. Manufacturers therefore play a large role in preventing or mitigating potential shortages by having rigorous quality assurance and risk management processes in place and contingency plans to respond to a drug shortage—for example, redundancy built into manufacturing capabilities to allow continued production even if the main manufacturing site experiences problems, or identification of alternative active pharmaceutical ingredient and component suppliers in the event the original supplier becomes unavailable.

FDA supports provisions encouraging manufacturers to institute such policies, consistent with our recommendations in the draft guidance for industry, Notification to FDA of Issues that May Result in a Prescription Drug or Biological Product Shortage.

LAB FUNDING

Question. The largest requested budget increase is $17.7 million to outfit a new biodefense and life sciences laboratory complex currently being constructed at FDA's White Oak facility. This new lab will support essential research by FDA scientists to protect patients and consumers. I understand that construction is nearly complete, and this funding will fully equip the lab and make the complex operational so research can begin there in 2014.

If this funding is provided, will there be any additional costs beyond this, or will this particular project be complete?

Answer. The increase of $17.7 million for fiscal year 2013 is required for special facility-related costs for outfitting, commissioning, and providing the essential equipment and infrastructure for the laboratories to be certified and operational. In subsequent years, FDA must determine how to replace aging laboratory equipment that cannot be moved from the existing laboratories and other equipment issues.

Question. What will the effect be if this funding is not provided, or is only partially provided? Is this a scalable project?

Answer. These costs have a direct relationship to the highly specialized construction of state-of-the-art laboratories. There are unique, one-of-a-kind installations and commissioning requirements needed to ensure acceptable operation of these facilities. The BSL–3 labs need to be in place and operational in 2013 to ensure they are certified for occupancy. Delay in certification will lead to the reduced ability to make advances in regulatory science, including efforts by scientists to do applied research and support regulatory decisionmaking in the areas of medical countermeasures and complex and novel product applications involving stem cells, tissues, blood and blood products, and vaccines. This building was designed in support of the consolidated Center for Biologics Evaluation and Research (CBER) Life Sciences-Biodefense Lab requirement to meet FDA's mission. If funding is not provided and commissioning is not completed as scheduled, notifications will have to be provided to landlords of the existing facilities and leases will have to be extended. This will lead to rental payments on both facilities causing the programs to absorb these added costs. This project is not a scalable project. If the full $17.7 million is not received, certification will not be achieved and the facility will not be operational.

Question. Is this the FDA's top priority for this fiscal year?

Answer. This is FDA's top facilities priority in the fiscal year 2013 budget.

USER FEES

Question. Dr. Hamburg, in your statement, you point out that of FDA's total budget request, 98 percent of the requested increase will come from user fees, including current user fees and seven new proposed fees.

Can you speak briefly about the status of each of the new user fees?

Answer. The following is a summary of the status of FDA's new user fees:

PRESCRIPTION DRUG USER FEE AMENDMENTS OF 2012

The proposed Prescription Drug User Fee Amendments of 2012 (PDUFA), Generic Drug User Fee Amendments of 2012 (GDUFA), and Biosimilar User Fee Act of 2012 (BsUFA) were submitted to the appropriate authorizing committees of the Congress on January 13, 2012, and are currently being considered by Congress. The draft legislative package for the Medical Device User Fee Amendments of 2012 (MDUFA) was submitted to Congress on April 20, 2012; this is also currently being considered by Congress.

MEDICAL PRODUCT REINSPECTION

Regarding the Medical Products Reinspection User Fee, the Administration has not submitted a proposal for medical product reinspection user fees at this time.

However, FDA is ready to work with Congress and stakeholders to advance this user fee program. A fee structure and related proposals would be developed through negotiations with industry and other stakeholders.

COURIER

Regarding the International Courier User Fee, the Administration has not submitted a proposal for authorizing this user fee at this time. However, FDA is ready to work with Congress and stakeholders to advance this user fee program. A fee structure and related proposals would be developed through negotiations with industry and other stakeholders.

COSMETICS

FDA has met with industry representatives to discuss their ideas for possible new authorities, such as mandatory facility registration and ingredient listing. FDA is ready to work with Congress and stakeholders to advance this user fee program. A fee structure and related proposals would be developed through negotiations with industry and other stakeholders.

FOOD CONTACT NOTIFICATION USER FEE

The Administration has not submitted a proposal for authorizing this user fee at this time. The Administration has not submitted a proposal for authorizing this user fee at this time. FDA is ready to work with Congress and stakeholders to advance this user fee program. Industry has previously expressed support for user fees to ensure continuation of the Food Contact Notification (FCN) program. A fee structure and related proposals would be developed through negotiations with industry and other stakeholders.

FOODS AND VETERINARY MEDICINE PROGRAM

Regarding the Food Establishment Registration Fee, the Administration has not submitted a proposal for authorizing this user fee at this time. However, FDA is ready to work with Congress and stakeholders to advance this user fee program. A fee structure and related proposals would be developed through negotiations with industry and other stakeholders.

FDA recommends that the proposal authorize the agency to establish a system of food establishment registration user fees to support food safety activities. The programs and activities that the fee will support are: Establishing new, effective, and comprehensive food safety standards, establishing a new program for import safety, increasing the number and efficiency of inspections, launching an integrated national food safety system with States and localities, expanding research activities, including improved data collection and risk analysis, and maintaining a current facilities registration database and supporting other information technologies to improve FDA's risk-based decisionmaking capabilities.

Question. I do understand that user fees allow FDA to raise additional funds without additional budget authority, but it is striking that so much of your proposed budget growth is slated to come from new fees, which obviously must be negotiated with the affected industries.

Does this concern you? Do you believe FDA could be hampered in its ability to function when so much of its budget is dependent upon fees that must be paid by, and therefore agreed to, by the industries FDA regulates?

Answer. The job of protecting patients and consumers requires stable and adequate sources of funding. FDA has benefited from user fees since the introduction of PDUFA in 1993. It is only appropriate that the industries who directly benefit from the actions taken at FDA pay a moderate fee to increase capacity at the agency. At a time when the availability of budget authority to support FDA programs is constrained, user fees provide an essential source of funding to conduct product reviews and ensure product quality and safety.

DRUG LABELING DURING PREGNANCY

Question. I have been working with you and the FDA to improve drug labels for women during their pregnancies. As you know, an estimated 75 percent of pregnant women use about five prescriptions or over-the-counter drugs during their pregnancies. The FDA proposed rules to make drug labeling easier to understand and easier to use for women during pregnancy. This process began 15 years ago with the FDA's Pregnancy Labeling Task Force and led to a proposed rule in 2008. As of today, 4 years later, these rules have not yet been finalized.

In previous inquiries, you told me that pregnancy drug labeling is a priority for FDA. If this rule is a priority, can you commit to me that FDA will finalize these labeling requirements by the end of this year?

Answer. FDA is committed to finalizing a rule that will improve drug labeling for women who are pregnant, and we are diligently working to issue this important rule. Because of the complexity of this rule and the time required to review and finalize this rule, it is not possible to say whether the final rule will publish during 2012.

However, we want to emphasize that, in addition to finalizing the pregnancy and lactation rule, FDA has other important and ongoing projects related to the health of pregnant and lactating women. For example, on April 30–May 1, 2012, as part of the FDA Medical Countermeasures Initiative (MCMi), FDA held a "Public Workshop on Developing Animal Models of Pregnancy to Address Medical Countermeasures for Influenza."

In addition, FDA has issued five scientific guidance documents relating to pregnancy and lactation that support women's health:

—Integration of Study Results to Assess Concerns about Human Reproductive and Developmental Toxicities (final guidance);
—Establishing Pregnancy Exposure Registries (final guidance);
—Pharmacokinetics During Pregnancy and Lactation (draft guidance);
—Evaluating the Risks of Drug Exposure in Human Pregnancies (final guidance); and
—Clinical Lactation Studies-Study Design, Data Analysis, and Recommendations for Labeling (draft guidance).

SEAFOOD CONSUMPTION DURING PREGNANCY

Question. In 2004, your agency published an advisory to pregnant women on seafood nutrition, which, unfortunately, had a negative consequence and was interpreted as a warning for all Americans to limit or stop consuming seafood altogether based on concerns over mercury. According to FDA's own data, pregnant women have reduced their seafood consumption to less than 2 ounces per week since that advisory was issued. The updated U.S. Dietary Guidelines for Americans, released over a year ago, recommend that pregnant women eat at least 8 ounces of seafood per week—a quadrupling of current levels.

Given the stark scientific evidence that women of childbearing years, pregnant women, and mothers with young children are eating too little seafood for their health and their babies' health, when will FDA finalize and publish an updated advisory for seafood consumption for pregnant women?

Answer. FDA agrees that the fish consumption advice issued in 2004 jointly by FDA and the Environmental Protection Agency (EPA) is in need of an update. We have been working together to issue draft new advice for public comment this year.

Question. One of the problems with the current FDA advice to pregnant women is it takes a "risk only" approach that has been misinterpreted by consumers and the media as Federal advice to reduce or stop seafood consumption.

What is the FDA doing to ensure that the updated advice is drafted in a way that includes both benefits and risks and is understandable to the average consumer?

Answer. The Administration currently has several conflicting opinions on seafood advice to pregnant women. NOAA recently released a video called "Fish, Mercury, and Nutrition: The Net Effects" which includes a virtual "who's who" of leading Government and academic scientists that lay out the science of why eating fish is important for all Americans, especially pregnant and breastfeeding moms. The scientists in the video question the 12 ounce consumption limit created by the FDA stating that it limits the benefits accrued from seafood consumption. The Washington Post ran an article on the front page of the Health section earlier this month that highlighted how the current conflict in seafood advice is confusing consumers.

Question. How is the Administration working together to ensure that there is consistent advice across all Federal departments and agencies to pregnant women on the consumption of seafood during pregnancy?

Answer. FDA agrees that the fish consumption advice issued in 2004 jointly by FDA and the Environmental Protection Agency (EPA) needs an update. FDA and EPA have been working together to issue draft new advice for public comment this year.

As you point out, the 2004 advice was risk oriented, in that its primary objective was to limit exposure to methylmercury during pregnancy. Methylmercury is a neurotoxin and the developing fetus can be particularly sensitive to it. Since that advice issued, a number of research studies have consistently indicated that fish consumption during pregnancy can benefit fetal neurodevelopment even though the fish contain at least some methylmercury. The research further indicates that for most fish, greater consumption can be more beneficial than less consumption, at least up to some point. Evidence shows, however, that the methylmercury in the fish can affect the size of the benefit, or, if exposure is high enough, whether there is a benefit at all. Too much methylmercury could still lead to neurodevelopmental deficits.

Taking these findings into account, the Departments of Agriculture and Health and Human Services updated the Dietary Guidelines for Americans that the two agencies publish every 5 years to recommend that pregnant women eat more fish. As you noted, the Dietary Guidelines for Americans 2010 essentially modified the 2004 FDA–EPA advice by adding a consumption target of 8–12 ounces per week of a variety of fish lower in methylmercury to promote cognitive development. The 2004 advice does not contain a consumption target and, in that respect, is now inconsistent with the advice in the Dietary Guidelines for Americans 2010.

In another development, FDA has performed a quantitative assessment of the net effects of fish consumption during pregnancy on fetal neurodevelopment that has produced results supportive of a consumption target in the range recommended in the Dietary Guidelines for Americans 2010. The FDA assessment was published in draft in 2009 and is now being prepared for publication in final form.

Updated advice should be consistent with the 8–12 oz. per week consumption target for pregnant women for commercial fish as is now recommended in the Dietary Guidelines for Americans 2010. That objective has been fully recognized by FDA and EPA in their joint effort to update their advice. Although updated advice could retain a short list of fish that women should probably avoid during pregnancy—as the Dietary Guidelines for Americans 2010 now does—the advice should also be crafted in a way that does not scare women away from a consumption target well beyond what most women are now eating. Median fish consumption by pregnant women in an FDA survey was 1.8 ounces per week, as you have noted.

It is also imperative that the advice have a solid scientific and analytical basis that is in the public domain. We expect that basis to consist of the research published since 2004, the FDA assessment as described above, and another assessment of the net effects of fish consumption published recently by the Food and Agriculture Organization of the United Nations and the World Health Organization. That assessment produced results consistent with the FDA assessment.

SEAFOOD SAFETY

Question. Dr. Hamburg, the safety of imported seafood is a significant concern. FDA does not currently have the resources to inspect seafood at the point of origin, and is inspecting less than 2 percent of imported seafood. However, we understand that many seafood buyers already require testing of product in the country of origin, and use third-party organizations, including qualified laboratories, to do this testing. This does have the advantage of detecting unsafe product before it enters the United States. Last year, in both the Senate Report and Conference Statement of Managers, we directed FDA to develop a comprehensive program for imported seafood.

What are you doing to implement this directive? In particular, does FDA currently have the authority to recognize third-party inspection and testing in seafood, and, if so, are you giving this concept any consideration?

Answer. FDA regulates imported seafood by, among other things, reviewing U.S. Customs entries, conducting field exams, collecting samples for laboratory analysis, and placing products and processors with a history of problems on detention without physical examination—requiring the importer to demonstrate compliance, usually through third-party analysis, for future shipments. These procedures address the control of pathogens, filth, parasites, decomposition, animal drugs, bio-toxins, and illegal food and color additives in imported fish and fishery products, among other hazards.

The implementation of the Seafood Hazard Analysis Critical Control Program (HACCP) regulation in 1997 initiated a landmark program designed to increase the safety that U.S. consumers already enjoyed and to reduce seafood related illnesses to the lowest possible levels.

Under the HACCP system of controls, the importer and the foreign processor share the responsibility for seafood safety. Foreign processors that ship fish or fishery products to the United States must operate in conformance with the seafood HACCP regulation. In addition, importers are required to take steps to verify that their imported products are obtained from foreign processors that comply with the seafood HACCP regulation. Compliance is verified through inspections.

The FDA Food Safety Modernization Act (FSMA) directs FDA to establish a program for accreditation of third-party auditors to conduct food safety audits to assess foreign food firms for compliance with FDA requirements. Based on audit results, accredited third-party auditors may issue certifications to foreign food firms. In addition, FSMA authorizes FDA to set up a program for accredited laboratories to perform food testing. Neither program is specific to seafood or to any other particular commodity. However, the FSMA requirement is consistent with the report language asking FDA to develop a comprehensive program for imported seafood.

BLOOD PLATELETS

Question. A recent study in Transfusion showed that the vast majority of bacterially contaminated platelet units are being missed by culture testing performed by the blood collectors and that testing on the day of transfusion detected more than twice as many contaminated units in an inventory where the culture positives had already been removed. While patients can be assured that there is virtually no risk of viral contamination in transfused blood products in the United States, the same cannot be said for bacterial contamination. It is estimated that 1 of every 3000 units of platelets being transfused is contaminated with bacteria at clinically significant levels. What is the FDA doing to make the medical community aware of the safety risks to transfusion patients from bacterially contaminated blood platelets?

Answer. FDA has the vital role of ensuring the safety of the approximately 17 million donations of Whole Blood and Red Blood cells collected from approximately 11 million donors each year. These Whole Blood donations are processed into approximately 23 million components, including platelets, which are transfused to approximately 4.5 million recipients

Bacteria may contaminate platelet products if bacteria are introduced during collection or through the presence of transient bacteremia in blood donors. Because platelets are stored at room temperature, if the product is contaminated, the bacteria can proliferate throughout the storage period. To improve the safety of platelet products, collection centers have implemented a number of measures over the past several years.

FDA has been diligent in its research and regulatory efforts to address and improve the safety of platelet transfusion. FDA has sponsored numerous workshops and advisory committee meetings and taken regulatory actions to address issues related to the bacterial contamination of platelets. Dating back to 1986, FDA reduced the shelf life of platelets from 7 days to 5 days based on reports of septic reactions. In 2003, FDA approved blood bags that facilitate diversion of the first 15 ml of blood collected into a diversion pouch in order to reduce the possibility of bacterial contamination.

FDA has also cleared several bacterial detection devices for the quality control of platelet products. For example, in 2009 FDA cleared the Verax Platelet PGD® Test System for use as a quality control test for the detection of bacteria after platelets derived from whole blood have been pooled, just prior to a patient platelet transfusion. However, because of the complexity involved with the implementation of this test and its variable sensitivity in the detection of bacteria, further consideration is warranted prior to recommending its routine use. Given the continued risk of bacterial contamination of platelets, FDA will continue to collaborate with the transfusion community and will consider implementing additional measures that may further improve the safety of platelet transfusions as technology develops.

RARE AND NEGLECTED DISEASES

Question. The Food and Drug Administration plays an essential role in capacity-building abroad to help build strong regulatory authorities in other nations. In addition, FDA's funding for new global health tools and its leadership in reviewing and licensing global health technologies is key to sustaining and supporting American investment in this area.

In the 2010 Appropriations legislation for FDA, Congress directed FDA to establish review groups on rare diseases and on neglected diseases of the developing world and to report to Congress on the agency's development of guidance for development of new technologies in these areas.

Would you please provide the Committee an update on the monitoring, evaluation and progress of the "Pathway to Global Product Safety and Quality"? In the update, please provide the following information in discussing the review of drugs and other products for neglected diseases:

—The frequency and barriers to the use of priority review;

—Ways to work with sponsors to facilitate expanded access to investigational products;

—Ways FDA can increase coordination and interaction with the World Health Organization, European Medicines Agency, and other international regulatory agencies on these drugs and products;

—Ways FDA can implement mechanisms to enhance collaboration between the Food and Drug Administration and National Regulatory Authorities in developing countries;

—Ways FDA can increase coordination among individual drug, biological product, and device review divisions across Food and Drug Administration centers to support the development and monitoring of safe and effective medical products for rare and neglected diseases.

Answer. The Pathway to Global product Safety and Quality is a major shift in the regulatory posture of intercepting harmful or contaminated medical products, to anticipating and preventing the arrival of violative and unapproved goods in the United States. As part of its global transformation, FDA is building an international operating model that relies on enhanced intelligence, information-sharing, data-driven risk analytics and the smart allocation of resources through partnerships. The following information addresses the separate issue of review of products for rare and neglected tropical diseases and the collaboration with stakeholders to develop and monitor drug development in this area.

The Frequency and Barriers to the Use of Priority Review

FDA has an existing priority review policy that is described in our Manual of Policy and Procedures. Products that qualify for priority review based on demonstrating an advantage will receive priority review based on the merits of the drug. FDA also prioritizes review of applications for antiretroviral drug products associated with the President's Emergency Plan for AIDS Relief (PEPFAR Program) drugs, as discussed below, and applications for drugs that are in short supply. There are no barriers to the application of the priority review policy.

The Tropical Disease Priority Review Voucher Program

Regarding the Tropical Disease Priority Review Voucher program, to date, that program, implemented in 2007, appears to have provided limited, if any stimulus to development of drugs for neglected tropical diseases. One voucher has been issued and redeemed to date. This voucher was received for the approval of artemether-lumefantrine tablets—Coartem®—for treatment of malaria, and the voucher was redeemed for the review of canakinumab for treatment of gouty arthritis.

Ways To Work With Sponsors To Facilitate Expanded Access to Investigational Products

FDA has specific provisions in its regulations, which were updated just a few years ago, to facilitate access to investigational drugs when the primary purpose is to diagnose, monitor, or treat a patient's disease or condition. The details in FDA regulations appear at 21 CFR 312 Subpart I—Expanded Access to Investigational Drugs for Treatment Use. This revision of the investigational new drug (IND) regulations, promulgated in 2009, was intended to clarify the procedures for obtaining investigational drugs for treatment use, by describing in detail three categories of expanded access to investigational drugs: Provides clarity for sponsors in characterizing expanded access of investigational products for individual patient use, for use in intermediate-sized patient populations, and for use in a treatment IND or treatment protocol. FDA also issued a companion rule at that time on charging for investigational products, to clarify and expand the number of scenarios where charging would be permitted.

Ways FDA Can Increase Coordination and Interaction With the World Health Organization (WHO), European Medicines Agency (EMA), and Other International Regulatory Agencies on These Drugs and Products

The Center for Drug Evaluation and Research (CDER) interacts with WHO, EMA, and other international regulatory agencies on an increasingly frequent basis on a variety of review issues. These interactions have promoted a familiarity with one another's programs and processes and lead to increased collaboration on numerous review-based activities.

An example is our collaboration with WHO on the review of antiretroviral drug products associated with the President's Emergency Plan for AIDS Relief (PEPFAR) program. FDA actively worked with companies to facilitate the development and review of applications for fixed dose combination products, in order to help ensure consistent availability of these products under PEPFAR for use in treatment programs.

FDA and the European Medicines Agency collaborate on a regular basis on orphan product designation and development. There is a common application form for submission to both agencies for orphan designation. Sponsors may file a common Annual Report to both agencies. Sponsors are encouraged to seek parallel scientific advice on orphan product development from both agencies. FDA most recently met with the European Union and Japanese regulatory agencies on the common application last February in Japan while at the International Conference for Rare Diseases and Orphan Drugs.

EMA has a program involving WHO which may assist in the development of neglected diseases outside our respective territories, and FDA participates in this program when sponsors seek parallel scientific advice.

With regard to the "Pathway to Global Product Safety and Quality" Report, FDA, EMA, European National Competent Authorities, the European Directorate for the Quality of Medicine, WHO, and Australia's Therapeutic Goods Administration collaborate on information-sharing and joint inspections of the manufacturers of active pharmaceutical ingredients. The program focuses on best use of international inspectional resources and information to help secure the global supply chain.

Ways FDA Can Implement Mechanisms To Enhance Collaboration Between the Food and Drug Administration and National Regulatory Authorities in Developing Countries

Since September 2005, CDER has offered the CDER Forum for International Drug Regulatory Authorities every spring and fall. The first nine programs focused on an overview of the CDER review process and major offices. Starting with the 10th program, the focus shifted to the review process and specifically the information posted at DRUGS@FDA to promote a more detailed understanding of the CDER's Review process and the scientific disciplines involved. The CDER Forums are very interactive and promote the possibility of drug regulatory authorities to learn from one another in a collegial way.

To date, regulators from more than 70 countries have participated. Worthy of note is that many countries have now included this activity in their budgets to allow staff to participate in the program on a regular basis.

Interactive modules have been created from CDER Forum lectures and they may be found on the CDER Web site under CDER World. Details on the CDER forum and other activities may be found in FDA's recently published report Global Engagement.

Ways FDA Can Increase Coordination Among Individual Drug, Biological Product, and Device Review Divisions Across Food and Drug Administration Centers To Support the Development and Monitoring of Safe and Effective Medical Products for Rare and Neglected Diseases

In 2010, the Center for Drug Evaluation and Research (CDER) established a rare diseases program to increase coordination among the individual offices and review divisions within the Office of New Drugs on the review and regulation of rare diseases and orphan products. This program is due to expand in fiscal year 2013 under the Prescription Drug User Fee Act (PDUFA) V, with increased staff, staff training, guidance, policy and advice generation, and increased coordination and outreach among rare disease stakeholders both within and outside of FDA. PDUFA V will also establish a rare disease liaison within the Center for Biologics Evaluation and Research (CBER) with similar responsibilities. The proposed PDUFA V legislation should contribute to and continue to enhance existing efforts at CDER to facilitate, support, and accelerate rare disease drug development.

To help facilitate medical device applications for rare diseases, the Center for Devices and Radiological Health (CDRH) released final guidance on the Humanitarian Device Exemption (HDE) process in July 2010 as well as draft guidance on the Humanitarian Use Devices (HUD) designation process (with CBER and the Office of Orphan Product Development) in December 2011. The proposed User Fee Amendment legislation should promote increased use of the HDE pathway for devices to treat rare pediatric and adult conditions and further the goal of the availability of medical devices for pediatric populations through continued funding of the consortia grants for medical device development.

Question. It is my understanding that Chagas disease is not on the list of neglected diseases as currently defined by the FDA.

Please explain why this is not the case and how the agency could include Chagas disease in its list of neglected diseases in line with the WHO list of Neglected Tropical Diseases.

Answer. In addition to the list of tropical diseases provided in section 524(a)(3), other infectious diseases for which there is no significant market in developed nations and that disproportionately affects poor and marginalized populations could be designated as tropical diseases by regulation (section 524(a)(3)(Q)). We have heard from other stakeholders in public comments to us that Chagas disease should be added to the list of neglected tropical diseases. FDA is considering this suggestion as we work through the rulemaking procedures for designating other diseases as tropical diseases. FDA has reviewed a list of tropical infectious diseases that are not specifically listed in section 524(a)(3) and will provide a discussion of why or why not we are to proposing to designate them as tropical diseases in the Notice of Proposed Rulemaking.

QUESTIONS SUBMITTED BY SENATOR DIANNE FEINSTEIN

ANTIBIOTICS

Question. In 2010, nearly 12.5 million kilograms of antibiotics were used in animal agriculture. It is widely believed that the vast majority of these drugs were given in low doses to healthy animals for the sole purpose helping them gain weight. The overuse of antibiotics in animals has contributed to bacteria resistance and new, more deadly forms of bacteria that were once easily treatable.

Commissioner Hamburg, the Food and Drug Administration's (FDA's) announcement calling on drug companies to help limit the use of antibiotics given to farm animals is a step in the right direction. However, it is important to note that the new guidance is voluntary, and I have real doubts that this industry will make these changes willingly.

What steps are you taking to ensure that companies that do not voluntarily revise their antibiotic use, cause no additional harm to human health?

Answer. FDA is confident that the cooperative framework outlined in the draft Guidance for Industry (GFI) No. 213, Revising Approved Conditions of Use for New Animal Drugs and New Animal Drug Combination Products Administered in or on Medicated Feed or Drinking Water of Food-Producing Animals, will help limit the use of antibiotic given to farm animals, which is why we are initially pursuing this voluntary approach. FDA anticipates that sponsors of affected products should be able to complete implementation of the changes discussed in this draft guidance within 3 years from the date of publication of the final version of this guidance.

FDA will continue to monitor the progress of the voluntary adoption strategy, including the progress of measures intended to facilitate an orderly and minimally disruptive transition. Three years after issuing the final version of GFI No. 213, FDA intends to evaluate the rate of adoption of the proposed changes across affected products. FDA will consider further action, as warranted or required, in accordance with existing provisions of the Food, Drug, and Cosmetic Act (FD&C Act) for those products that have not been updated with the recommended changes through the voluntary process.

Question. How much do you expect this policy to reduce the total volume of antibiotic use, in terms of kilograms? What metrics are you using to judge the success of this initiative?

Answer. At this time, FDA does not have detailed drug use data that would enable us to estimate quantitatively the reduction in the total volume of use that would be expected with phasing out the production or growth promotion uses of medically important drugs. However, FDA does believe that eliminating production uses and limiting remaining use to address animal disease under the direction of a veterinarian represents a significant change to how these drugs have been used for decades in animal agriculture.

As discussed in FDA's Guidance for Industry (GFI) No. 209, "The Judicious Use of Medically Important Antimicrobial Drugs in Food-Producing Animals," a key objective is to limit the use of medically important antimicrobial drugs in food-producing animals to those uses that are necessary for addressing animal health needs. Animal health needs are to treat, control, or prevent a specifically identified disease. Such uses typically involve drug administration at higher, therapeutic doses, for shorter durations to targeted animals that have a disease or are at risk of disease. In contrast, production or growth promotion uses are not necessary for maintaining animal health. Such uses are not intended to manage any disease and typically involve administering drugs at lower drug doses for prolonged durations to entire herds or flocks of animals.

FDA acknowledges the importance of assessing the effectiveness of measures intended to curb antimicrobial resistance. However, identifying appropriate metrics is challenging. In conjunction with finalizing its plans for implementing the recommendations outlined in GFI No. 209, FDA is considering approaches for assessing the impact of such measures over time. This includes exploring mechanisms for enhancing the drug sales and distribution data that it already receives and other metrics such as data provided by the National Antimicrobial Resistance Monitoring System (NARMS), to track trends in antimicrobial resistance over time.

Question. How does this announcement interact with the recent court ruling that will require FDA modify its approved uses of penicillin and tetracycline?

Answer. FDA is continuing its work with the animal pharmaceutical industry, veterinarians, and producer and consumer groups to ensure the judicious use of antimicrobials of human health importance. FDA is studying the opinion and determining how this will affect the voluntary approach outlined in GFI No. 209.

However, to the extent that the court's decision, dated March 22, 2012, is not ultimately reversed on appeal, and if sponsors have not already voluntarily withdrawn the growth promotion indications for their penicillin and tetracycline drug products used in animal feed, the application of the court's opinion would appear to require FDA to initiate mandatory withdrawal proceedings pursuant to section 512(e) of the FD&C Act. The Court's opinion does not address any other medically important antibiotics. Thus FDA does not believe that the March 22 decision precludes FDA from continuing to pursue the voluntary approach to phasing out growth promotion uses for those other drugs. In addition, the court's decision does not affect FDA's implementation of the second principle in GFI No. 209, which uses a voluntary approach to phase in veterinary oversight for approved therapeutic uses of medically important antimicrobial drugs in the feed or water of food-producing animals.

ARSENIC IN CHICKEN STUDIES

Question. Commissioner Hamburg, I was recently made aware of the John's Hopkins Center for a Livable Future study which suggests that poultry are fed banned antibiotics, low levels of arsenic, caffeine, and over-the-counter drugs—all illegal—in an effort in fatten them up and keep the meat tender.

This concerns me, because consumers have no way of knowing if the chicken they are consuming have been fed these dangerous chemicals.

How is the FDA responding to the industry's use of illegal chemicals in poultry?

Answer. FDA is aware of the recent studies published in Science of the Total Environment and in Environmental Science and Technology that analyzed chicken feather meal for bioaccumulated levels of arsenic and certain pharmaceuticals and personal care products. Scientists at FDA Center for Veterinary Medicine (CVM) are currently working to evaluate the methods used in and conclusions drawn by these studies. FDA takes this kind of information very seriously and, based on the outcome of our evaluation, will act accordingly.

FDA has conducted its own scientific investigation to determine whether the use of the arsenic-based animal drug, roxarsone, causes carcinogenic residues in edible tissues of chickens. As part of this work, FDA scientists developed an analytical method capable of detecting inorganic arsenic in edible tissues. FDA scientists found that the levels of inorganic arsenic in the livers of chickens treated with 3–Nitro, also known as roxarsone—were increased relative to levels in the livers of the untreated control chickens. Based on this information, FDA met with the drug sponsor, Alpharma LLC, a subsidiary of Pfizer Inc., and developed a plan to address the concerns raised by the study. As a result, the drug sponsor voluntarily suspended the sale of the product in the United States.

In addition, FDA and the United States Department of Agriculture's Food Safety Inspection Service (FSIS) and the Environmental Protection Agency (EPA) continue to work collaboratively to control and monitor veterinary drug, pesticide, and environmental contaminant residues in FSIS-regulated foods. FSIS, through the National Residue Program, tests meat, poultry and egg products to verify that tolerances or action levels are not violated. When FSIS identifies violations, FDA uses its enforcement tools to address the violation. This includes issuing warning letters and seizures and injunctions. Throughout the years, the two agencies have pursued a number of cases which have resulted in consent decrees.

Question. What research do you have that suggests that drugs like Prozac and Benadryl are safe food additives or food animal drugs?

Answer. As mentioned above, scientists at FDA's Center for Veterinary Medicine (CVM) are currently working to evaluate the study that reported finding residues of these drugs and other compounds in feather meal. At this time, FDA has no evidence that U.S. poultry producers are adding these chemicals to animal feed and it remains unclear whether other factors are involved, including exposure to environmental sources of these compounds. As this is the first study to examine feather meal for these types of compounds, additional research is needed to verify the results and to investigate exposure sources.

FOOD SAFETY

Question. In May 2011, the U.S. Department of Agriculture (USDA) received a petition to declare antibiotic-resistant salmonella as an "adulterant" in poultry. This would mean that products containing these bacteria could not be sold. I would support any decision that protects consumers from dangerous pathogens, particularly if that decision allowed USDA to recall contaminated poultry before consumers get sick.

Is FDA collaborating with USDA on this issue of antibiotic-resistant organisms in meat?

Answer. Yes, FDA and USDA have worked together on this issue since 1997 when USDA joined FDA's NARMS program. USDA Hazard Analysis and Critical Control Point (HACCP) samples, which are tested for antibiotic resistance, include retail meat products in the sampling design. The results of this work are published in the NARMS annual reports on FDA's Web site. In conjunction with HACCP sampling, FDA continues to collaborate with USDA on the collection of additional isolates that are more representative of food animal production. Additionally, with respect to monitoring the use of antibiotics in other nations, FDA works in conjunction with USDA's Food Safety Inspection Service when residues are identified in imported meat and meat products.

Question. The most recent data produced by the FDA's National Antimicrobial Resistance Monitoring System (NARMS) shows that nearly 30 percent of poultry tested contain antibiotic resistant strains of salmonella. But the monitoring system doesn't even test for highly dangerous and resistant bacteria such as methicillin-resistant Staphylococcus aureus (MRSA).

Are there any plans to expand the scope of this important monitoring tool?

Answer. Yes, needed improvements are being made to the sampling design for the food animal component of NARMS that will result in more reliable data on antibiotic resistance trends. NARMS is an important monitoring tool and it is critical to have a flexible program that is able to address current and emerging challenges. Regarding MRSA specifically, FDA is well aware of the recent research on this issue. FDA, the Centers for Disease Control (CDC), and USDA are in agreement that the epidemiology of community-associated MRSA does not point to the food supply as an important mechanism for spreading this infection.

FOOD SAFETY MODERNIZATION ACT

Question. Commissioner Hamburg, on January 4, 2011, the President signed the Food Safety Modernization Act into law. This law ensures that we are working to prevent foodborne pathogens from entering the food supply rather than just responding to outbreaks. However, it is now more than a year since enactment and we still have not seen many of the regulations required by this law.

Will you please provide an update on the timeline for the full implementation of the Food Safety Modernization Act?

Answer. The numerous provisions of the FDA Food Safety Modernization Act (FSMA) present FDA with a unique opportunity to improve food safety. This also represents an enormous challenge to develop and issue more than 50 regulations, guidance documents, and reports under very tight timeframes. FDA is committed to issuing all of the rules and regulations in FSMA and is prioritizing its work by concentrating first on the rulemakings that will form the foundation of the preventive controls framework envisioned in FSMA. FDA currently has four FSMA proposed rules—Preventive Controls for Human Food, Preventive Controls for Animal Food, Produce Safety Standards, and the Foreign Supplier Verification Program—currently under review with the goal to issue these documents as soon as possible.

Question. How does FDA plan to differentiate between high-risk and low-risk products?

Answer. The provisions of the FDA Food Safety Modernization Act (FSMA) contain many references to high-risk and low-risk products, facilities, activities, or situations. FSMA frequently mandates that FDA consider risk and be risk-based in its actions. In some sections, FSMA provides criteria for evaluating risk and in other sections it does not. For example, section 204—Enhancing Tracking and Tracing of Food and Recordkeeping—states that each designation of a high-risk food shall be based on:

> "(i) the known safety risks of a particular food, including the history and severity of foodborne illness outbreaks attributed to such food, taking into consideration foodborne illness data collected by the Centers for Disease Control and Prevention;
>
> "(ii) the likelihood that a particular food has a high potential risk for microbiological or chemical contamination or would support the growth of pathogenic

microorganisms due to the nature of the food or the processes used to produce such food;

"(iii) the point in the manufacturing process of the food where contamination is most likely to occur;

"(iv) the likelihood of contamination and steps taken during the manufacturing process to reduce the possibility of contamination;

"(v) the likelihood that consuming a particular food will result in a foodborne illness due to contamination of the food; and

"(vi) the likely or known severity, including health and economic impacts, of a foodborne illness attributed to a particular food."

In implementing the various provisions of FSMA, FDA will consider the specific text related to risk in the relevant section and then, to the extent the text allows, strive to be consistent in our implementation across the provisions.

REGISTRY OF LEGITIMATE ONLINE PHARMACIES

Question. The Internet has made it shockingly easy for patients to obtain—and become addicted to—prescription drugs. In a report published in January, the National Association of Boards of Pharmacy found that 96 percent of the nearly 9,000 Internet drug outlets it reviewed were not in compliance with pharmacy laws or established industry standards.

These Web sites are increasingly sophisticated, making it difficult for consumers to distinguish between legitimate online retailers and those that unlawfully sell prescription drugs. Oftentimes, illegal online pharmacies impersonate the layout of legitimate pharmacies; claim to be endorsed by Government agencies; or display licenses, phone numbers, and addresses, all to deceive consumers.

I have introduced bipartisan legislation with Senators Sessions, Cornyn, and Schumer to protect consumers from these rogue Internet pharmacies. Because it is so difficult for consumers to distinguish the legitimate online pharmacies from the illegitimate ones, the bill as introduced proposes that FDA create a registry of legitimate pharmacy Web sites. This would make sure consumers are protected by providing accurate information about the legitimacy of pharmacy Web sites. I understand that FDA staff has some concerns with this approach. But the Internet is not going anywhere, and neither is the problem posed by rogue pharmacy Web sites.

Will you work with me to devise solutions to better educate consumers so that they can make informed decisions when they seek to purchase prescription drugs online?

Answer. One of our concerns with establishing a list or registry of "legitimate" online pharmacies as a resource for consumers is that the unregulated nature and volume of Web sites on the Internet would make it nearly impossible to monitor and maintain such a list with any form of real-time accuracy of the legitimacy of the online pharmacies. FDA does not have the ability to assure that every site listed in such a registry would always remain safe at the time of purchase. Despite being listed as "legitimate," an online pharmacy may later decide to sell or dispense illegal products that may cause consumers harm. Additionally, criminals could also use the list to target online pharmacies and masquerade as a listed Web site to sell unapproved, adulterated, or counterfeit medicines. Therefore, consumers could be misled into thinking that the Web sites listed were completely safe sites from which to buy medicines.

FDA looks forward to working with you and other stakeholders on solutions for empowering consumers to make informed decisions when they are considering purchasing prescription drugs online. FDA is committed to educating the public on how to safely buy prescription medicines online and about the risks associated with purchasing prescription drugs on the Internet from illegal Web sites. We currently have educational materials available on FDA's Web site, http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/BuyingMedicinesOvertheInternet/default.htm, and continue to research consumer and healthcare professional perceptions about buying prescription drugs online in order to improve these educational materials.

DEFINITION OF VALID PRESCRIPTION

Question. An estimated 1-in-6 Americans—36 million people—have purchased prescription medication online without obtaining a valid prescription. This has contributed to a growing prescription drug abuse in our Nation.

For example, a man in Wichita, Kansas took eight or nine pills of the muscle relaxant Soma each night to help him sleep, even though the recommended dosage is only one pill every 6 to 8 hours. One morning, his wife found him dead in bed from an accidental overdose of this drug. She had assumed that the pills were being prescribed by a doctor, but she was wrong. Her husband had obtained the drugs from an illegal Internet pharmacy without ever visiting a doctor.

In another example from my home town, a doctor in San Francisco wrote thousands of prescriptions for painkillers for customers of a rogue Internet pharmacy. The prescriptions were based on brief telephone conversations. The doctor never examined or even met the patients. One patient, who also lived in San Francisco, became addicted to narcotics and developed liver damage after receiving multiple orders of the pain killer Darvocet.

These tragedies occurred because there is a loophole in current law that allows prescriptions for noncontrolled substances to be issued without a patient ever visiting a doctor. In 2008, Congress enacted legislation that I had introduced—the Ryan Haight Online Pharmacy Consumer Protection Act—that requires that a patient receive at least one in-person medical evaluation before prescriptions could be issued for a drug that is a controlled substance. It is time that we extend this provision to cover all prescription drugs, not just controlled substances, and I have introduced bipartisan legislation with Senators Sessions, Cornyn, and Schumer that would achieve this result.

I know that the President's U.S. Intellectual Property Enforcement Coordinator has issued reports that call for "valid prescription" to be defined in the law for prescription drugs that are not controlled substances.

Could you describe why the Administration has taken this position?

Answer. The Administration is correct in being concerned about the lack of a clear Federal definition of a "valid" prescription for the purposes of online drug sales of non-controlled substances. Although it will not solve all problems associated with Internet sales of prescription drugs, creating a national definition of a valid prescription would be helpful to broadly address some of the challenges associated with Internet pharmacies. A uniformly applicable definition of what constitutes a "valid" prescription would be beneficial for all prescription drugs as an enforcement tool, regardless of whether they are controlled or non-controlled substances.

Prescription drugs may only be dispensed upon a prescription ordered by a State-licensed healthcare practitioner for specific patients based on a medical need determined by that healthcare practitioner. To ensure the safe use of a prescription drug, the drugs should be used under the supervision of a licensed healthcare practitioner by law to administer such drug (section 503(b) of the Food Drug & Cosmetic Act).

Illegal online drug sellers (including many located outside the United States) pretend to be legitimate Internet pharmacies and offer prescription drugs for sale without requiring that the purchaser have a valid prescription for such drugs.

FDA is concerned about the public health risks associated with consumers buying prescription drugs from online drug sellers on the Internet, because some of these products, particularly those sold without requiring a valid prescription, may be ineffective and unsafe. Specifically, illegal Internet pharmacies are more likely to offer products that are counterfeit, contaminated, contain the wrong active ingredient(s), have too much or too little active ingredient, are not stored or handled under proper conditions, or are produced under filthy conditions. As a result, consumers may experience adverse health effects.

FDA has several examples demonstrating our concern for the public's safety when using illegal Internet pharmacies to buy prescription drugs:

- —A dangerous counterfeit product that was purchased using the Internet, that contained the wrong active ingredient: http://www.abbott.com/vicodin-consumer-alert.htm
- —A past advisory about foreign products with confusing names or the same name, but that may have different active ingredients than the FDA-approved drug: http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHeathcareProfessionals/PublicHealthAdvisories/ucm173134.htm
- —FDA found that products purchased from "Canadian pharmacies" actually came from 27 different countries: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2005/ucm108534.htm

To help U.S. consumers who buy prescription drugs on the Internet protect themselves from receiving unapproved, unsafe, and ineffective drugs, FDA recommends that they buy only from online pharmacies that:

- —Are located in the United States;
- —Are licensed by the State board of pharmacy where the Web site is operating;
- —Have a licensed pharmacist available to answer questions;
- —Require a prescription from a doctor or other healthcare professional licensed to prescribe in order to buy a prescription medicine; and

—Provide contact information that allows the consumer to talk to a person if he or she has problems or questions.

Additional advice to consumers about how to buy medicines online safely can be found on FDA's Web site at: http://www.fda.gov/Drugs/ResourcesForYou/ucm080588.htm

NUTRITION LABELING STANDARDS

Question. I have heard from constituents in my State who own restaurant chains like Carl's Junior and Domino's. They are concerned about the implementation of the final rule of section 4205 of the Patient Protection and Affordable Care Act, Nutrition Labeling of Standard Menu Items at Chain Restaurants.

These restaurant chains, which employ thousands of people in my State, are concerned that the implementation of this final rule could be overly burdensome, particularly in these challenging economic times.

I appreciate your request for comments on many parts of the proposed rule, including on the use of stanchions, the declaration of variable menu items, and a discussion of different options for the final rule.

The FDA estimates the initial mean cost of complying with the requirements of the rule will be $315 million, with an estimated ongoing cost of over $44 million. I believe this regulation should be implemented in a way that is the least burdensome. In what ways is the FDA working with industry to ensure the final regulations are the least burdensome and least costly?

Answer. FDA conducted multiple listening sessions with the industry and other stakeholders when developing the proposed rule. The industry supplied numerous comments in response to the proposed rule and FDA is giving these comments careful consideration in development of the final rule.

FDA examined the impacts of the proposed rule as required under Executive Orders 12866 and 13563, the Regulatory Flexibility Act (5 U.S.C. 601–612), and the Unfunded Mandates Reform Act of 1995 (Public Law 104–4). Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits (both quantitative and qualitative) of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

In addition, FDA evaluated the impacts of the proposed rule pursuant to the Regulatory Flexibility Act, which requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. FDA's analysis of the regulatory impact of the proposed rule was made available for public comment and FDA is considering the comments received in developing the final rule.

Question. Will you allow any flexibility in deadlines for small businesses to comply with the regulations?

Answer. FDA proposed that the final rule become effective 6 months from the date of its publication. FDA also requested comments on whether the effective date should be extended for a greater period of time after the publication of the final rule (76 FR 19192 at 19219). FDA also sought comment on whether we should provide for staggered implementation based on the size of a chain or of a specific franchisee (76 FR 19192 at 19220). FDA is reviewing and considering the comments and will include its decisions on the effective date and on staggered implementation in the final rule.

Question. What is the status of the final rule?

Answer. FDA is currently reviewing and considering the comments, and developing the final rule.

Question. Does the FDA have a target date for implementing the final rule?

Answer. FDA will specify the effective date in the final rule when it is published.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

BIOSIMILARS USER FEE PROGRAM

Question. When Congress adopted the Biologics Price Competition and Innovation Act (BPCIA), it did so to ensure a consistent standard during the review process, as well as the same level of expertise with the reviewers as the Prescription Drug User Fee program. As a result of BPCIA, FDA has recently submitted a fee proposal for the review of biosimilar products to Congress.

As a part of this legislative package, why is FDA proposing an additional $20 million in appropriated funds, commonly referred to as a trigger, for each of the program's 5 years?

Answer. Under the "Biosimiliars User Fee Act of 2012" (BsUFA), FDA will allocate at least $20 million, adjusted for inflation, in non-user fee money for biosimilar review activities to ensure that user fees represent supplemental funding to the biosimilar program and to avoid redirection of resources from PDUFA to BsUFA activities.

Question. Does BPCIA include a specific requirement to develop this separate funding trigger?

Answer. BPCIA does not include a specific requirement for funding, but directs FDA to develop a biosimilar user fee program for fiscal years 2013 through 2017. Similar to FDA's other medical product user fee programs, under BsUFA, user fee funding supplements dedicated non-user fee funding to ensure sufficient resources for the biosimilar review program.

BIOSIMILARS

Question. How did FDA arrive at the $20 million figure, and what data or information did you use to support at that number? Is FDA currently spending appropriated funds on activities related to biosimilars?

Answer. FDA considers the review of biosimilar biological products, which offer the potential for a safe and effective, and more affordable alternative to innovator biologics to be a high priority. FDA has devoted an increasing amount of resources to the biosimilar program since BPCIA enactment in March 2010. FDA is developing regulatory policies and guidance on the new biosimilar approval pathway, and building the review capacity to facilitate biosimilar biological product development. On February 9, 2012, FDA released three draft guidance documents on biosimilar product development. The draft guidances are "Scientific Considerations in Demonstrating Biosimilarity to a Reference Product", "Quality Considerations in Demonstrating Biosimilarity to a Reference Protein Product", and "Biosimilars: Questions and Answers Regarding Implementation of the Biologics Price Competition and Innovation Act of 2009." FDA is currently seeking comments on the guidance documents and will consider information received from the public in finalizing the documents. FDA is spending appropriated funds on activities related to biosimilars. During fiscal year 2011, FDA spent $7.9 million on biosimilar activities.

Characterizing biological products for the purpose of determining biosimilarity or interchangeability is challenging because the molecules of biological products tend to be much larger and have a far more complex spatial structure than small-molecule drugs. Therefore, FDA generally expects the level of effort and expertise required to review biosimilar applications to be comparable to that required to review innovator biologic applications. As a result, the proposed fee levels under BsUFA are similar to the fee levels under PDUFA. Industry agreed to these fee levels only if FDA committed to review performance goals that would quickly become comparable to the goals of the more mature, established PDUFA program. As a result, the proposed performance goals for BsUFA include goals related to meetings with sponsors, application review, and other biosimilar review activities. For certain goals, the target performance levels start at 70 percent and increase to 90 percent by the fifth year of the program, while others begin at 90 percent and remain at this level for the 5 years of the program.

Although FDA has been meeting with, and providing advice to, sponsors of biosimilar product candidates since May 2010, FDA has not received a biosimilar biological product application, and there are no currently marketed biosimilar biological products. The biosimilar program is relatively new, leading to uncertainty regarding future program size and user fee collections. To ensure resources for biosimilar review activities, while avoiding redirection of resources from PDUFA, FDA estimated at least $20 million in non-user fee money plus biosimilar user fee collections would be required to have sufficient minimum program staffing capacity to be able to achieve these aggressive performance goals in the first 5 years of the BsUFA program.

Question. Does this new trigger require Congress to appropriate an additional $20 million specifically for the biosimilar program each year?

Answer. BsUFA does not require Congress to appropriate funds for the biosimilar program, but requires FDA to spend at least $20 million each year, adjusted for inflation, in non-user fee money for biosimilar review activities.

Question. If the FDA intends to reallocate or reprogram the $20 million from other FDA existing programs and accounts, from precisely what programs and in what amounts would the funding be derived?

Answer. FDA considers the review of biosimilar products to be a high priority. In fiscal year 2011, FDA received an increase of $1.8 million in non-user fee money for the biosimilar review program. For fiscal year 2013, if FDA does not receive approximately $20 million in new budget authority for the biosimilar review program, then FDA must reassess other priorities, and redirect budget authority funding from other programs.

DEVICES AND DIAGNOSTICS

Question. Guidance documents can be a useful tool to provide flexible, rapid direction to industry and agency personnel on FDA policy or issues. However, the proliferation of guidance documents issued by FDA, particularly the Center for Devices and Radiological Health, has created some confusion in the industry. Issuing numerous guidance documents on related topics over a short timeframe creates a patchwork of industry responsibilities that may be difficult to navigate. The agency claims this "mosaic" will fit together smoothly once all the pieces are issued; however, it is difficult to see the agency's vision.

Dr. Hamburg, can you help me understand FDA's end strategy regarding these guidance documents?

Answer. In recent years concerns have been raised both within and outside of FDA about our regulatory review processes. In August 2010, the Center for Devices and Radiological Health (CDRH) released two reports that identified issues regarding our premarket programs and proposed potential actions for us to take to address the underlying root causes. After considering extensive and varied public input on our recommendations, in January 2011, CDRH announced a Plan of Action that included 25 specific actions that we would take to improve the predictability, consistency, and transparency of our premarket programs.

The Plan of Action outlines which recommendations CDRH intends to implement including the identification of eight specific guidance documents that will help CDRH to better meet its mission of protecting and promoting the public health. To date six of the eight originally identified guidance documents have been issued in draft.

FDA believes the actions identified in the Plan for Action, including the associated guidance documents, will strengthen our premarket review programs. By increasing the predictability, reliability, and efficiency of our regulatory pathways, FDA can help ensure that better treatments and diagnostics are provided to patients more quickly, stimulate investment in and development of promising new technologies to meet critical public health needs, and increase the global market position of U.S. medical devices.

A detailed report informing constituents of the many actions CDRH is undertaking to improve its premarket programs is available on FDA's Web site: (http://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDRH/CDRHReports/ucm276272.htm).

Question. Until recently, FDA has exercised enforcement discretion when diagnostic products labeled Research Use Only (RUO) are used in clinical settings. Some are concerned that ending this practice will result in manufacturers discontinuing many RUO products, thus limiting patient access to innovative diagnostics, particularly in the personalized medicine arena.

Can you comment on whether you believe FDA is striking the right balance between protecting the public health and ensuring patient access to new therapies?

Answer. FDA believes that products intended for use in patient diagnosis should not be marketed or distributed with the label, "For research use only. Not for use in diagnostic procedures." FDA has not had a policy of enforcement discretion for Research Use Only—or RUO—labeled products that are marketed for clinical diagnostic use. Our regulations, promulgated in 1976, require manufacturers to label products consistent with their intended use. Because RUO products are not intended to affect patient care, they are exempt from the safety-oriented regulatory controls applied to medical devices that are intended for diagnostic use. This exemption facilitates the marketing and shipping of devices that are intended for research use only by not requiring the same level of regulatory controls that are required for devices which are used to make patient management decisions.

The RUO draft guidance was issued June 11, 2011. The policies outlined in the draft guidance are supported by longstanding statutory and regulatory requirements; the RUO labeling regulation was originally promulgated on March 15, 1973, and the definition of intended use for devices was promulgated on February 13, 1976. The purpose of the draft guidance is to leverage our enforcement resources by reminding companies that these regulatory requirements exist, that FDA does enforce them, and that by ignoring these regulations, companies may be causing their devices to be adulterated and/or misbranded under the Federal Food, Drug, and Cosmetic Act.

In finalizing the guidance, we will carefully consider how the guidance might affect access and availability of certain products, and will take steps to assure that the public health is not put at risk.

Question. It has been brought to my attention that FDA's recent guidance on Research Use Only products could restrict patient access to important diagnostics by restricting sales of these products. Does the agency have any evidence of patients being harmed by Research Use Only products? What is the agency's sense of the scope of this perceived problem?

Answer. Because RUO products are exempt from the usual regulatory controls applied to medical devices, including exemption from registration of the manufacturer and listing of the devices sold, and the requirement to report adverse events to FDA, we do not typically receive reports of RUO device failures and malfunctions, or any adverse events related to such failures and malfunctions. However, we have encountered examples of advertisements, package inserts, and other marketing materials in which a device labeled for research use and not in compliance with FDA device regulations is promoted for clinical diagnostic use. We are also aware of anecdotal evidence that use of such products may have contributed to incorrect diagnoses, and errors in public health actions.

We believe that clinical diagnostic use of products that are not labeled for diagnostic use and do not comply with FDA regulations presents safety concerns, in part because there is no assurance that such products are manufactured in any controlled way. There is also no assurance that such products perform as stated, that manufacturers will address problems with these products, that there will be uniformity between products of the same type, or that potential users will be notified if the products are defective or could cause harm.

In finalizing the guidance, FDA will carefully consider how the guidance might affect access and availability of certain products, and will take steps to assure that the public health is not put at risk.

Question. FDA's current regulatory principles hold manufacturers responsible only for their own actions and clearly state that "intended use" is determined by objective actions taken by the manufacturer, such as product claims. Under the draft RUO guidance, FDA's position on this matter has changed significantly. The draft guidance states that a product is subject to regulation based on how a customer uses the product, even if the manufacturer has labeled and promoted it properly.

What is the basis for FDA's position that a manufacturer's knowledge of its customer's use of the product—rather than the manufacturer's conduct—makes the product subject to device regulations?

Answer. We do not believe the draft RUO guidance represents a significant change, as the regulations governing RUO labeling and the definition of intended use that underlie the policies announced in the draft guidance have been in place since 1973 and 1976 respectively. Under these regulations, a manufacturer has the responsibility to label devices consistent with their intended use, and intended use may be shown by the circumstances surrounding the distribution of the device, including knowledge of actual use. We have observed a striking increase in marketing of products that clearly have a diagnostic purpose under the RUO label, and wish to remind manufacturers that putting an RUO label on a product and then marketing it for diagnostic use is violative.

We consider a number of factors when determining whether a manufacturer is in violation of the labeling requirements and believe a "totality of the evidence" approach is appropriate to determining whether a manufacturer has acted in accordance with the regulations.

MENU LABELING

Question. FDA is currently working on the final rule in regards to menu labeling. This is a tremendous undertaking for restaurants. Specifically, the law recognizes that the making of restaurant meals is different than manufacturing packaged foods and thus was explicit about the use of "reasonable basis" to enforce the law.

Do you intend to follow the intent of the law in regards to uniform enforcement with "reasonable basis"? What is your current thinking on how to approach this issue?

Answer. Section 4205 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) states that "a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration" (21 U.S.C. 343(q)(5)(H)(iv)). FDA specifically requested comment on the appropriateness of its compliance approach in the proposed rule (76 FR 19192 at 19218). The comment period for the proposed rule closed on July 5, 2011, and FDA received comments, including comments from other members of Congress, on the issue of reasonable basis. We assure you that FDA will consider alternative solutions to address this complex issue. We evaluate all comments before issuing a final rule.

ANTIMICROBIAL RESISTANCE

Question. What are the metrics FDA will use to measure "success" of the recently released Guidance No. 209?

Answer. FDA acknowledges the importance of assessing the effectiveness of measures intended to curb antimicrobial resistance, but recognizes that identifying appropriate metrics as indicators of "success" is challenging. In conjunction with finalizing its plans for implementing the recommendations outlined in Guidance for Industry (GFI) No. 209, "The Judicious Use of Medically Important Antimicrobial Drugs in Food-Producing Animals," FDA is considering approaches for assessing the impact of such measures over time. This includes looking at other metrics such as, exploring mechanisms for enhancing the drug sales/distribution data that we already receive and National Antimicrobial Resistance Monitoring System (NARMS) data to track trends in antimicrobial resistance over time.

Question. The National Antimicrobial Resistance Monitoring System (NARMS) has been a collaboration between FDA, the Centers for Disease Control (CDC), and USDA. I have been informed that FDA is planning on discontinuing funding to USDA while continuing to fund CDC. If NARMS data is one potential metric to be used to measure the impact of Guidance No. 209 does FDA feel that program can be viewed as impartial and unbiased if the FDA does not have input from outside HHS in survey design and data collection?

Answer. FDA has been working collaboratively with its USDA and CDC partners in developing a strategy for instituting enhancements to the NARMS program. We do not expect this strategy to reduce total funding to USDA, but rather it provides for a redeployment of funding within USDA to provide for significant improvements in sampling design for the food animal component of NARMS. The NARMS program has and will continue to be a collaborative effort between FDA, CDC, and USDA. The changes that are currently under development will serve to enhance the NARMS program and strengthen the utility of its data for supporting efforts to address antimicrobial resistance.

Question. If metrics such as antibiotic resistance do not decrease, what does FDA see as next steps?

Answer. As noted above, identifying appropriate metrics for assessing the effectiveness of measures implemented to curb antimicrobial resistance is challenging. In addition, FDA expects that such metrics will need to be observed over a number of years in order to identify any trends in the data. The strategy outlined in Guidance No. 209 and draft Guidance No. 213 represents an appropriate path forward for addressing this important public health issue in a manner that also ensures that animal health needs continue to be met. If following implementation of the recommended changes, assessments do not indicate positive effect. FDA will evaluate what additional measures, if any, may be needed.

QUESTIONS SUBMITTED BY SENATOR JERRY MORAN

ADDRESSING DRUG SHORTAGES

Question. Has the Food and Drug Administration (FDA) evaluated whether policies and regulations of the Drug Enforcement Administration (DEA) have contributed in any manner to the drug shortage problems we are currently seeing in our country?

Answer. FDA and DEA are continuing to work together to address evolving and potential drug shortages of critical care medications and prescription drugs. FDA applies the full range of regulatory and administrative tools available and engages in extensive cooperative efforts with DEA to manage issues associated with this public health crisis. These efforts are designed to avoid the concern raised by your question.

Question. Does the FDA study or plan to study whether DEA policies and regulations contribute to drug shortage problems?

Answer. FDA is not studying whether DEA policies and regulations contribute to drug shortage problems. However, we understand that the Government Accountability Office (GAO) intends to conduct a study of the extent to which the Drug Enforcement Administration policies and regulations contribute to the growing drug shortage crisis with regard to controlled substances prescribed by physicians. FDA will support this GAO study as needed.

Question. What collaborative efforts does FDA engage in with the DEA to address drug shortages that may be caused by some degree by current DEA quotas?

Answer. FDA is very concerned about drug shortages and is working diligently with firms, stakeholders, and other Federal agencies as appropriate. The amount of raw material that a firm can make of a controlled substance is under the purview of DEA. However, when firms have notified FDA that additional raw material is needed to avoid shortages of controlled substances, FDA has worked closely with DEA to notify DEA of the potential for shortage. FDA and DEA are continuing to work together to address evolving and potential drug shortages of critical care medications and other prescription drugs. At this time, FDA is working closely with DEA to respond to shortage reports being shared with both organizations.

MENU LABELING

Question. As you stated, and was stated in the proposed rule, one of the alternatives that FDA is considering is option 2, which would narrow the scope of menu labeling regulations to only restaurants and retail establishments whose primary business is the selling of restaurant or restaurant-type food. Since I'm assuming that the proposed rule was cleared by FDA's General Counsel's office, then FDA can implement the restaurant menu labeling regulations under the option 2 alternative and remain in compliance with the law, correct?

Answer. Section 4205 of the Affordable Care Act requires that certain chain restaurants and similar retail food establishments disclose nutrition information for standard menu items. As we discussed in the proposed rule, the statutory term "restaurants and similar retail food establishments" is ambiguous, and it is possible to imagine a range of interpretations.

FDA proposed an interpretation alongside alternatives for public comment (76 FR 19192 at 19195–19196). Accordingly, in the proposed rule, FDA presented the approach of option 2 as an alternative to the proposed definition of "restaurant or similar retail food establishment" (76 FR 19192 at 19198), and considered the costs and benefits of option 2 as a regulatory alternative under Executive Orders 12866 and 13563 (76 FR 19192 at 19223). Option 2 includes requirements similar to the proposed rule, but defines "restaurant or similar retail food establishment" as retail establishments where the sale of restaurant food or restaurant-type food—as opposed to food in general—is the primary business activity. Option 2 covers all establishments included in the proposed rule, with the exception that grocery and convenience stores would not be subject to the proposed requirements. FDA specifically requested comment on the proposed definition of "restaurant or similar retail food establishment" and on the alternatives, and is reviewing and considering the comments received as we are developing the final rule.

Question. Can you explain how President Obama's Executive Order 12866 and Executive Order 13563 have impacted your proposed implementation? Would the option 2 alternative fulfill Executive Order 12866 and Executive Order 13563 by minimizing burdens while achieving the statutory directives? Can you demonstrate that you are taking the least burdensome path in implementing these regulations?

Answer. Under Executive Orders 12866 and 13563, FDA examined the regulatory impacts of the proposed rule and assessed the costs and benefits of a number of regulatory alternatives. The proposed rule reflects FDA's tentative conclusion that the benefits of the proposed rule justify the costs as required by Executive Order 12866, and that the proposed rule is "the least burdensome tool for achieving [the] regulatory ends" of the statute as required by Executive Order 13563. In the proposed rule, FDA identified option 2 as a regulatory alternative to the proposed rule, and assessed its benefits and costs. We will review and consider comments on our preliminary regulatory impact analysis of the proposed rule and the regulatory alternatives in selecting the regulatory approach in the final rule that minimizes costs and maximizes net benefits.

Question. Can you explain why, under "option 1" or the proposed rule itself, you use foods that already have nutritional information labeled or displayed under the Nutrition Labeling and Education Act (NLEA) as a trigger for establishments to be captured under this regulation?

Answer. FDA considered comments received prior to the publication of the proposed rule as well as the language and purpose of section 4205 when considering the scope of establishments covered by section 4205 and deliberating on how to define "restaurants and similar retail food establishments" in the proposed rule. FDA proposed that that the term “restaurant or similar retail food establishment” means a retail establishment that offers for sale restaurant or restaurant-type food, where the sale of food is the primary business activity of that establishment (76 FR 19192 at 19197). FDA refers to this definition in the Preliminary Regulatory Impact Analysis (PRIA) as “option 1.”

In the proposed rule, FDA also offered an alternative to this proposed definition. Under this alternative, a restaurant or similar retail food establishment means a retail establishment where the sale of restaurant or restaurant-type food—as opposed to food in general is the primary business activity of that establishment (76 FR 19192 at 19198). Therefore, neither the proposed definition of “restaurant or similar retail food establishment” nor the alternative definition uses the sale of packaged food that is required to bear nutrition information on its label under the Nutrition Labeling and Education Act (NLEA) as the trigger for establishments to be covered by section 4205. FDA asked for comment on the proposed and alternative definitions as well as any other option for defining the term “restaurants and similar retail food establishments.”

We further note that in the proposed rule, FDA tentatively concluded that some packaged food offered for sale in covered establishments is “food served in restaurants or other establishments in which food is served for immediate consumption or that is sold for sale or use in such establishments,” and would therefore meet the definition of “restaurant food.” To the extent that packaged food is “restaurant food” and otherwise satisfies the requirements of section 4205, such packaged food would be covered by the menu labeling requirements. FDA recognizes that such packaged food includes on its label the nutrition information required by the NLEA and in the proposed rule, has provided some flexibility to industry for satisfying the requirements of section 4205 (76 FR 19192 at 19217).

Question. In the proposed rule, FDA uses the term “restaurant-type” food even though that term is nowhere in the statute. Can you explain how you came up with that term and then why you created a new food category (restaurant-type food) to cover another category beyond “restaurant food”?

Answer. The 1990 NLEA amendments included exemptions for nutrition labeling for two categories of food:

—Food “which is served in restaurants or other establishments in which food is served for immediate human consumption or which is sold for sale or used in such establishments,” and

—Food “which is processed and prepared primarily in a retail establishment, which is ready for human consumption, which is the type described in [(1)] and which is offered for sale to consumers but not for immediate human consumption in such establishment and which is not offered for sale outside such establishment” (21 U.S.C. 343(q)(5)(A)(i) and (ii)).

The terms “restaurant food” and “restaurant-type food,” as used in the proposed rule, reflect these two categories of food. As explained in the proposed rule, we looked to this statutory context as a starting point for developing a regulatory definition of the term “restaurants and similar retail food establishments,” as used in section 4205 of the Affordable Care Act (76 FR 19192 at 19196). We are reviewing and considering comments that address the scope of establishments covered by section 4205 as we develop the final rule.

Question. Have you accounted for how much the proposed rule’s definition of “restaurant-type” food, as “food not sold for immediate consumption, but ready for human consumption and processed or prepared in a retail establishment”, which is sold at practically every grocery store, expands the scope of the regulations?

Answer. In the proposed rule, FDA proposed that a restaurant or similar retail food establishment be defined as a retail establishment that offers for sale restaurant or restaurant-type food, where the sale of food is the primary business activity of that establishment (61 FR 19192 at 19233). The proposed rule—option 1—therefore encompasses grocery stores that are chain retail food establishments as defined in the proposed rule. In the proposed rule, FDA also estimated the cost of an alternative to this proposed definition—option 2—that limits the definition of “restaurant or similar retail food establishment” to retail establishments where the sale of restaurant food or restaurant-type food is the primary business activity, and therefore excludes grocery stores from the coverage of section 4205 (76 FR 19192 at 19223). Comparing option 1 to option 2 shows that covering grocery stores and convenience stores adds about $10.9 million to the cost of the proposed rule. FDA has received comments on the scope of establishments covered by section 4205 and will address this issue in its response to comments in the final rule.

Question. Have you accounted how the term “restaurant-type” food also expands the number of items that would be regulated, particularly for grocery stores?

Answer. The Preliminary Regulatory Impact Analysis (PRIA) did not estimate the extent to which the definition of restaurant-type food expands the number of items that would be regulated. FDA has received comments on this issue and will address this issue in its response to comments in the final rule.

Question. Please provide a revised estimate of the costs of option 1 to grocery stores based on your use of "restaurant-type food" and compare it with the costs estimated in your PRIA and by the Office of Management and Budget (OMB) in its September 2010 paperwork burdens report.

Answer. FDA has received comments on this issue and FDA is giving those comments careful consideration in the development of the final rule.

Question. In FDA's cost-analysis, there appears to be very few—if any—studies showing a change in diets, obesity rates, health costs, and clearly no economic benefit that can be attributed to menu labeling. Can you compare the economic benefits of expanding these regulations to grocery stores versus the added costs to retailers?

Answer. The Preliminary Regulatory Impact Analysis references the following studies showing a change in diets attributed to menu labeling:

—Bollinger, B., P. Leslie, and A. Sorensen. "Calorie Posting in Chain Restaurants." American Economic Journal: Economic Policy, 2011, 3(1): 91—128, 2011.

—Bassett, M. T., T. Dumanovsky, C. Huang, L. D. Silver, C. Young, C. Nonas, T. D. Matte, S. Chideya, and T. R. Frieden. "Purchasing Behavior and Calorie Information at Fast-Food Chains in New York City, 2007." American Journal of Public Health, 98(8):1457–59, 2008.

—Downs, J.S., G. Lowenstein, and J. Wisdom, J. "The Psychology of Food Consumption: Strategies for Promoting Healthier Food Choices". American Economic Review: Papers & Proceedings, 99(2): 159–164, 2009.

—Elbel, B., J. Gyamfi, and R. Kersh. "Child and Adolescent Fast-Food Choice and the Influence of Calorie Labeling: A Natural Experiment," International Journal of Obesity, Advance online publication, February 15, 2011.

—Elbel, B., R. Kersh, V. L. Brescoll, and L. B. Dixon. "Calorie Labeling And Food Choices: A First Look At The Effects On Low-Income People In New York City." Health Affairs, 28(6):W1110–W1121, 2009.

—Finkelstein, E.A., L. Kiersten, N.L. Strombotne, L. Chan and J. Krieger. "Mandatory Menu Labeling in One Fast-Food Chain in King County, Washington," American Journal of Preventive Medicine, 40(2):122–127, 2011.

—Tandon, P. S., J. Wright, C. Zhou, C. B. Rogers, and D. A. Christakis. "Nutrition Menu Labeling May Lead to Lower-Calorie Restaurant Meal Choices for Children." Pediatrics, 125(2):244–48, 2010.

—Yamamoto, J.A., J.B. Yamamoto, B.E. Yamamoto, and L.G. Yamamoto. "Adolescent Fast Food and Restaurant Ordering Behavior with and without Calorie and Fat Content Menu Information." Journal of Adolescent Health, 37: 397–402, 2005.

Comparing option 1 to option 2, FDA estimates that covering grocery stores and convenience stores adds about $10.9 million to the cost of the proposed rule. FDA spent a significant amount of time considering the regulatory impact of the scope of establishments covered by section 4205. FDA will continue to consider the costs and benefits of covering grocery stores as we develop the final rule, and will address this issue in its response to comments in the final rule.

Question. Have you factored in the cumulative effect of regulatory burdens that grocery stores already face as compared to restaurants?

Answer. Executive Order 13563, which states that to the extent permitted by law, each agency must take into account "among other things, and to the extent practicable, the costs of cumulative regulations," was issued on January 18, 2011. FDA published the proposed rule on April 6, 2011. The Office of Management and Budget (OMB) issued guidance on how to consider the cumulative effects of regulations, as directed by Executive Order 13563, on March 20, 2012, nearly 1 year after FDA published the proposed rule. FDA did not have sufficient time to estimate the cumulative effect of regulations for the proposed rule. However, FDA will carefully consider OMB's guidance, and to the extent permitted by law and practicable, FDA will take active steps to take account of the cumulative costs of new and existing rules in the final rule.

Question. The House Appropriations Committee included the following Report Language in support of FDA's option 2 alternative for restaurant menu labeling with the fiscal year 2012 Agriculture Appropriations bill that was later accepted by the Senate-House Conference Committee when it reached final agreement and approved FDA:

—*Nutrition Labeling.*—The Committee is concerned with the proposed rule that FDA issued on April 6, 2011, on nutrition labeling of standard menu items in

> restaurants and similar retail food establishments. The proposed rule would include establishments that are not primarily in the business of selling food for immediate consumption or selling food that is prepared or processed on the premises. These establishments are not similar to restaurants and the Committee believes that FDA should define the term "restaurant" to mean only restaurants doing business marketed under the same name or retail establishments where the primary business is the selling of food for immediate consumption. The Committee urges FDA to use the proposed alternative definition in the rule that would encompass only establishments where the primary business is the selling of food for immediate consumption or selling food that is prepared and processed on the premises.

Please explain how your agency has considered this report language.

Answer. In addition to the report language that you cite, FDA received comments in response to the proposed rule that also support option 2, the proposed alternative definition of "restaurant or similar retail food establishment." FDA will fully consider the comments received in response to the proposed rule as we develop our final rule. We want to clarify that under option 2, the term "restaurant or similar retail food establishment" means a retail establishment where the sale of restaurant or restaurant-type food—as opposed to food in general—is the primary business activity of that establishment. Restaurant-type food means food of the type described in the definition of restaurant food that is ready for human consumption, offered for sale to consumers but not for immediate consumption, processed and prepared primarily in a retail establishment, and not offered for sale outside the establishment. Therefore, option 2 would not define "restaurant or similar retail food establishment" to exclusively mean establishments where the primary business activity is the sale of food for immediate consumption.

INTERNAL EFFICIENCIES

Question. USDA Secretary Vilsack has procured significant savings from increased operational efficiencies within USDA. He has reduced travel, utilized early retirement programs, and consolidated cell phone contracts from over 700 to 10. Secretary Vilsack saved approximately $90 million with these actions. In addition, the Farm Service Agency (FSA) office consolidation initiative will save approximately $60 million a year. Has FDA considered any actions like these, as opposed to raising taxes on food makers? Perhaps you could look at eliminating duplication with State inspections, or maybe some internal budget reductions?

Answer. FDA has proposed savings as part of our fiscal year 2013 budget related to information technology expenditures. The estimate of IT savings for fiscal year 2013 is $19.7 million, and the savings will occur in three areas.

First, FDA has been working to consolidate its IT infrastructure into more modern data center facilities. During fiscal year 2013, we will realize $6.0 million in savings as due to our consolidation efforts. Second, we are launching an initiative to reduce the number of redundant laptops and other IT devices. This effort will produce $5.1 million in savings. Finally, other initiatives across all FDA programs will yield an additional $8.6 million in IT savings. The other initiatives include retiring legacy IT systems, modifying IT business processes, and other forms of IT database savings.

MEDICAL RESEARCH

Question. Since the FDA Accelerated Approval process began, of the 80 products approved under Accelerated Approval, 32 have targeted AIDS, 29 cancer, and 20 all other disorders. (Source: Janet Woodcock, "FDA User Fees 2012: How Innovation Helps Patients and Jobs," Statement before the Committee on Energy and Commerce Subcommittee on Health, U.S. House of Representatives, April 18, 2012, p. 7.) Similarly, a recent study by Friends of Cancer Research highlighted the agency's performance for oncology drugs, noting that most novel oncology products have been approved in the United States ahead of Europe. (Source: Samantha A. Roberts, Jeff D. Allen, Ellen V. Sigal, "Despite Criticism of the FDA Review Process, New Cancer Drugs Reach Patients Sooner in the United States," Health Affairs, June 2011.) Clearly, cancer is an area where agency processes seem relatively consistent and predictable. However, there is growing concern that in other important public health and unmet medical needs areas—diabetes, cardiovascular disease, obesity, and central nervous system (CNS) conditions for example—FDA review processes are viewed as increasingly unpredictable and inconsistent. Understanding that the science across these various areas are very different, what is the agency doing to improve these variances?

Answer. The Accelerated Approval program has been a great success in bringing innovative new drugs to patients with serious or life-threatening diseases in a timely manner. While it is true that the program has been used most often in approval of drugs to treat cancer and HIV/AIDS, Accelerated Approval applies across all therapeutic areas where the science supports approval and the conditions established in the statute and regulations are met. FDA is actively working to improve awareness of this pathway for interested stakeholders and FDA staff. There are other initiatives in place to accelerate development and approval of important new drugs, including the Fast Track Program, Rolling Review, and Priority Review. These programs apply across the spectrum of therapeutics and have been used frequently to facilitate rapid development and approval of innovative medicines. Moreover, FDA recognizes the need for these new drugs and actively works with sponsors to facilitate the development of their safety, effectiveness, and high quality. FDA conducts over 2000 formal meetings with drug sponsors each year to discuss drug development programs. Also, the FDA publishes guidance documents outlining its current thinking on topics such as development of a drug for a specific disease and broader topics such as use of adaptive trial designs.

Question. What metrics and data does the agency use, similar to that reported in the aggregate in its annual user fee performance reports, to monitor and address performance variances across its internal review divisions?

Answer. In the Center for Drug Evaluation and Research (CDER) and Center for Biologics Evaluation and Research (CBER), senior management conduct ongoing oversight of the advice given and decisions made by the therapeutic review divisions and we carefully track the performance of divisions in meeting PDUFA review goals. As part of the proposals for PDUFA V there will be programs to further strengthen FDA's capacity to respond to the rapidly changing science in areas such as pharmacogenomics, patient reported outcomes, meta-analyses, and rare disease drug development. These programs are expected to enhance our interactions with sponsors across the various therapeutic review divisions, which should streamline the development and approval of innovative new drugs to meet unmet medical needs.

ANIMAL ANTIBIOTICS

Question. Farmer's and rancher's number one priority is taking care of their livestock and producing a safe and healthy food supply. Recently FDA issued concerning guidance about antibiotic use that suggests farmers and ranchers are not caring for livestock in the most appropriate way possible.

Why did FDA issue this guidance?

Answer. Current science supports the finding that widespread use of antimicrobials for growth promotion in animals can contribute to the emergence of drug resistance which may be transferred to humans, thereby reducing the effectiveness of these drugs for treating human disease. To address this concern, FDA's Guidance for Industry No. 209 is intended to ensure that medically important antibiotics are used judiciously in food-producing animals by recommending a pathway to limit their use, in consultation with a veterinarian, to only address the health needs of animals, namely to treat, control, or prevent disease.

Question. Was this guidance based on peer reviewed science?

Answer. A variety of recognized international, governmental, and professional organizations have studied the judicious use of medically important antimicrobial drugs. Within the Guidance for Industry No. 209, "The Judicious Use of Medically Important Antimicrobial Drugs in Food-Producing Animals," we have briefly summarized the findings and recommendations from some of the notable reports and peer-reviewed scientific literature that have addressed this issue over the past 40 years. These reports provide context to FDA's current thinking on this issue, and highlight the longstanding concerns that have been the subject of discussion in the scientific community as a whole.

Question. Can you provide me with the scientific evidence that supports the guidance that you issued?

Answer. Below is a list of some of the scientific literature that FDA considered in developing the Guidance for Industry No. 209, including some key reports and peer-reviewed scientific literature. This list is not an exhaustive summary of the scientific literature, but only highlights some of the more recent scientific research related to the use of antimicrobial drugs in animal agriculture and the impact of such use on antimicrobial resistance. We acknowledge that a significant body of scientific information exists, including some information that may present equivocal findings or contrary views.

—1. 1969 Report of the Joint Committee on the Use of Antibiotics in Animal Husbandry and Veterinary Medicine.

—2. 1970 FDA Task Force Report, “The Use of Antibiotics in Animal Feed.”
—3. 1980 National Academy of Sciences Report, “The Effects on Human Health of Subtherapeutic Use of Antimicrobial Drugs in Animal Feeds.”
—4. 1984 Seattle-King County Study: “Surveillance of the Flow of Salmonella and Campylobacter in a Community.”
—5. 1988 Institute of Medicine (IOM) Report: “Human Health Risks with the Subtherapeutic Use of Penicillin or Tetracyclines in Animal Feed.”
—6. 1997 World Health Organization (WHO) Report, “The Medical Impact of Antimicrobial Use in Food Animals.” http://whqlibdoc.who.int/hq/1997/WHO__EMC__ZOO__97.4.pdf
—7. 1999 National Research Council (NRC) Report: “The Use of Drugs in Food Animals—Benefits and Risks.”
—8. 1999 United States Government Accountability Office (GAO) Report—“Food Safety: The Agricultural Use of Antibiotics and Its Implications for Human Health.” http://www.gao.gov/archive/1999/rc99074.pdf
—9. 1999 European Commission Report, “Opinion of the Scientific Steering Committee on Antimicrobial Resistance.” http://ec.europa.eu/food/fs/sc/ssc/out50__en.pdf
—10. 2000 World Health Organization (WHO) Expert Consultation: “WHO Global Principles for the Containment of Antimicrobial Resistance in Animals Intended for Food.” http://whqlibdoc.who.int/hq/2000/WHO__CDS__CSR__APH__2000.4.pdf
—11. 2003 Report, “Joint FAO/OIE/WHO Expert Workshop on Non-Human Antimicrobial Usage and Antimicrobial Resistance: Scientific assessment.” http://www.who.int/foodsafety/publications/micro/en/amr.pdf
—12. 2003 Institute of Medicine (IOM) Report, “Microbial Threats to Health: Emergence, Detection and Response.”
—13. 2004 Report, “Second Joint FAO/OIE/WHO Expert Workshop on Non-Human Antimicrobial Usage and Antimicrobial Resistance: Management options.” http://www.oie.int/fileadmin/Home/eng/Conferences__Events/docs/pdf/WHO-CDS-CPE-ZFK-2004.8.pdf
—14. 2004 United States Government Accountability Office (GAO) Report—“Antibiotic Resistance: Federal Agencies Need to Better Focus Efforts to Address Risks to Humans from Antibiotic Use in Animals.” http://www.gao.gov/new.items/d04490.pdf
—15. 2005 Codex Alimentarius Commission (Codex), “Code of Practice to Minimize and Contain Antimicrobial Resistance.” http://www.codexalimentarius.net/download/standards/10213/CXP__061e.pdf
—16. 2006 Antimicrobial Resistance: Implications for the Food System, Comprehensive Reviews in Food Science and Food Safety, Vol. 5, 2006.
—17. 2009. American Academy of Microbiology. Antibiotic Resistance: An Ecological Perspective on an Old Problem. 1752 N Street, NW, Washington, DC 20036, (http://www.asm.org).
—18. 2011. Tackling antibiotic resistance from a food safety perspective in Europe. World Health Organization (WHO), Regional Office for Europe Scherfigsvej 8, DK–2100 Copenhagen Ø, Denmark. http://www.euro.who.int/data/assets/pdf__file/0005/136454/e94889.pdf
—19. 2008. Longitudinal study of antimicrobial resistance among Escherichia coli isolates from integrated multisite cohorts of humans and swine. Alali WQ, Scott HM, Harvey RB, Norby B, Lawhorn DB, Pillai SD. Applied and Environmental Microbiology. 74(12):3672–81.
—20. 2008. Diversity and distribution of commensal fecal Escherichia coli bacteria in beef cattle administered selected subtherapeutic antimicrobials in a feedlot setting. Sharma R, Munns K, Alexander T, Entz T, Mirzaagha P, Yanke LJ, Mulvey M, Topp E, McAllister T. Applied and Environmental Microbiology. 74(20):6178–86.
—21. 2008. Effect of subtherapeutic administration of antibiotics on the prevalence of antibiotic-resistant Escherichia coli bacteria in feedlot cattle. Alexander, T.W., L.J. Yanke, E. Topp, M.E. Olson, R.R. Read, D.W. Morck, and T.A. McAllister. Applied and Environmental Microbiology. 74:4405–4416.
—22. 2009. A metagenomic approach for determining prevalence of tetracycline resistance genes in the fecal flora of conventionally raised feedlot steers and feedlot steers raised without antimicrobials. Harvey, R., J. Funk, T.E. Wittum, and A.E. Hoet. American Journal of Veterinary Research. 70:198–202.
—23. 2009. Association between tetracycline consumption and tetracycline resistance in Escherichia coli from healthy Danish slaughter pigs. Vieira, A.R., H. Houe, H.C. Wegener, D.M. Lo Fo Wong, and H.D. Emborg. Foodborne Pathogens and Disease. 6:99–109.

—24. 2009. Associations between reported on-farm antimicrobial use practices and observed antimicrobial resistance in generic fecal Escherichia coli isolated from Alberta finishing swine farms. Varga C., A. Rajic, M.E. McFall, R.J. Reid-Smith, A.E. Deckert, S.L. Checkley, and S.A. McEwen. Preventive Veterinary Medicine. 88:185–192.

—25. 2010. Farm-to-fork characterization of Escherichia coli associated with feedlot cattle with a known history of antimicrobial use. Alexander, T.W., G.D. Inglis, L.J. Yanke, E. Topp, R.R. Read, T. Reuter, and T.A. McAllister. International Journal of Food Microbiology. 137:40–48.

—26. 2011. Lower prevalence of antibiotic-resistant Enterococci on U.S. conventional poultry farms that transitioned to organic practices. Sapkota AR, Hulet RM, Zhang G, McDermott P, Kinney EL, Schwab KJ, Joseph SW. Environ Health Perspect. 119(11):1622–8.

—27. 2011. Association between antimicrobial resistance in Escherichia coli isolates from food animals and blood stream isolates from humans in Europe: An ecological study. Foodborne Pathogens and Disease. Vieira, A.R., P. Collignon, F.M. Aarestrup, S.A. McEwen, R.S. Hendriksen, T. Hald, and H.C. Wegener. 8:1295–1301.

—28. 2011. Distribution and characterization of ampicillin- and tetracycline-resistant Escherichia coli from feedlot cattle fed subtherapeutic antimicrobials. Mirzaagha P, Louie M, Sharma R, Yanke LJ, Topp E, McAllister TA. BMC Microbiol. 19;11:78.

—29. 2012. In-feed antibiotic effects on the swine intestinal microbiome. Looft, T., T.A. Johnson, H.K. Allen, D.O. Bayles, D.P. Alt, R.D. Stedtfeld, W.J. Sul, T.M. Stedtfeld, B. Chai, J.R. Cole, S.A. Hashsham, J.M. Tiedje, and T.B. Stanton. Proceedings of the National Academy of Sciences USA. 109:1691–1696.

FDA also considered other studies that were referenced by the Department of Health and Human Services in response to 2004 United States Government Accountability Office (GAO) report entitled, “Antibiotic Resistance: Federal Agencies Need to Better Focus Efforts to Address Risks to Humans from Antibiotic Use in Animals”:

—1. Phillips I, Casewell M, Cox T, et al. Does the use of antibiotics in food animals pose a risk to human health? A critical review of published data. J Antimicrob Chemother, 2004; 53:28–52.

—2. Holmberg SD, Wells JG, Cohen ML. Animal-to-man transmission of antimicrobial-resistant Salmonella: Investigations of U.S. outbreaks, 1971–1983. Science, 1984; 225:833–5.

—3. Holmberg SD, Solomon SL, Blake PA. Health and economic impacts of antimicrobial resistance. Rev Infect Dis, 1987; 9:1065–78.

—4. Lee LA, Puhr ND, Maloney K, et al. Increase in antimicrobial-resistant Salmonella infections in the United States, 1989–1990. J Infect Dis, 1994;170:128–34.

—5. Varma J, Mølbak K, Rossiter S, et al. Antimicrobial resistance in Salmonella is associated with increased hospitalization; NARMS 1996–2000. International Conference on Emerging Infectious Diseases. March 2002. Atlanta, Georgia.

—6. Varma J, Mølbak K, Rossiter S, et al. Antimicrobial resistance in non-typhoidal Salmonella is associated with increased hospitalization and bloodstream infection—United States, 1996–2000. 51st Annual EIS Conference. April 22–26, 2002. Atlanta, Georgia.

—7. Helms M, Vastrup P, Gerner-Smidt P, Mølbak K. Excess mortality associated with antimicrobial drug-resistant Salmonella Typhimurium. Emerg Infect Dis, 2002; 8:490–5.

—8. Martin L, Fyfe M, Doŕe K, et al. Increased burden of illness associated with antimicrobial-resistant Salmonella enterica serotype Typhimurium infections. J Infect Dis, 2004; 189:377–84.

—9. Smith KE, Besser JM, Hedberg CW, et al. Quinolone-resistant Campylobacter jejuni infections in Minnesota, 1992–1998. N Engl J Med, 1999; 340:1525–32.

—10. Neimann J, Mølbak K, Engberg J, et al. Longer duration of illness among Campylobacter patients treated with fluoroquinolones. 11th International Workshop on Campylobacter, Helicobacter, and Related Organisms, 1–5 September, 2001. Freiburg, Germany.

—11. Nelson JM, Smith KE, Vugia DJ, et al. Prolonged diarrhea due to ciprofloxacin-resistant Campylobacter infections. J Infect Dis, 2004; in press.

QUESTIONS SUBMITTED BY SENATOR JOHN HOEVEN

Question. I would like to ask you about the Food and Drug Administration's (FDA's) lack of enforcement action against companies that market products as being eyelash growth promoters, without FDA approval, when those products contain prostaglandin analogues (PGAs) or derivatives of PGAs. North Dakota has ophthalmologists who prescribe Latisse, the FDA-approved drug counterpart to these cosmetic products and I am concerned these alternative cosmetic products may pose a public health threat to those that purchase them, such that additional enforcement action may be beneficial.

I understand that this issue was raised before the House Appropriations Subcommittee on Agriculture on February 29, 2012, and you stated that you planned to further investigate the issue.

What have you and the agency done since that hearing in February to address this issue and, if necessary, to protect consumers?

Answer. Consistent with FDA priorities, resources, and legal authorities, FDA's objective is to identify, investigate, and take corrective action against violative products. If violations are identified, FDA uses a variety of enforcement tools to address these violations and to facilitate compliance and protect the public health. These tools include but are not limited to warning letters, seizures, injunctions, and criminal prosecution. We appreciate and share your concerns about the potential risks posed by eyelash products that contain PGAs or their derivatives and are marketed as cosmetics. FDA will communicate information regarding any action taken related to these products when that information is available for disclosure.

Question. Would the agency be willing to release a public health advisory about the health risks associated with the products so that the State Attorneys General can police the sale of these products, if necessary?

Answer. FDA shares your concern about these PGA-containing products marketed as cosmetics. FDA is considering your suggestion and is committed to protecting the public from potential harm. We encourage the ophthalmologists in your State to submit any adverse events related to these PGA-containing eyelash products to FDA's Medwatch Adverse Event Reporting program.

QUESTIONS SUBMITTED BY SENATOR FRANK R. LAUTENBERG

Question. The Family Smoking Prevention and Tobacco Control Act of 2009 specifically banned candy flavorings in cigarettes. Now, tobacco companies are using flavored cigars to encourage kids to smoke. Cigars with candy-like flavorings such as strawberry, watermelon, vanilla, and chocolate attract kids to smoking and help hook them on this addictive habit. An estimated 1.8 million high school students and 475,000 middle school students smoke cigars. The Centers for Disease Control (CDC) estimates that, in 13 States, more high school males smoke cigars than smoke cigarettes. Does the Food and Drug Administration (FDA) believe youth cigar smoking is a problem? What is the agency doing to stop this epidemic and appropriately regulate flavored cigars?

Answer. The restriction on cigarettes with characterizing flavors is in effect and is actively being enforced. With respect to products other than cigarettes, FDA is pursuing a proposed rule to deem all products meeting the statutory definition of "tobacco product" to be subject to the Food, Drug, and Cosmetic Act (FD&C Act). This would enable FDA to take further action with respect to flavorings in other tobacco products if FDA concludes that it is appropriate to do so in order to protect the public health.

FDA is currently engaged in research that is exploring the role that flavorings play in prompting the initiation and use of various tobacco products, particularly among youth. FDA is also continuing to evaluate the impact of menthol on youth initiation, and will determine what action, if any, is appropriate based on the scientific evidence.

Question. The myth of the healthier cigarette continues to threaten the well-being of Americans. For decades, tobacco companies claimed that some cigarettes were "light," "mild," or "low," misleading Americans about the safety of the products. The Family Smoking Prevention and Tobacco Control Act helped put an end to this deceptive marketing, specifically prohibiting companies from using terms like "light," "mild," "low," or "similar descriptors." However, the agency has failed to offer any regulations or guidance restricting the use of "similar descriptors," and cigarette companies continue to use words like "natural," "organic" and "smooth" to mislead consumers about the health of their products. When does the agency plan to issue guidance or regulations on the use of "similar descriptors"? What is the FDA doing to prevent this deceptive marketing?

Answer. FDA has been actively enforcing the modified risk tobacco product provisions of the FD&C Act, particularly the provisions that pertain to reduced risk of disease, reduced level or lack of a substance, and the use of the descriptors "light," "low," and "mild" on regulated tobacco product label, labeling, and advertising. FDA has not, at this time, issued a regulation or guidance that specifically defines the term "similar descriptors" and has been gathering information regarding descriptors that may be considered similar to "light," "low," or "mild" and could impact consumer perceptions of risk. This will help inform FDA's implementation and enforcement of the modified risk tobacco product provision, which could include, for example, providing additional guidance.

FDA is in the process of conducting consumer perception studies on terms that could be considered "similar descriptors." FDA will continue to pursue violations for label, labeling, or advertising where FDA has sufficient evidence of claims that the product presents a lower risk of tobacco related disease, a reduced level of or exposure to a substance, or is free of or does not contain a substance.

Question. Roll-your-own cigarette shops allow customers to make their own cigarettes. These stores exist in at least 15 States, including New Jersey, and I am concerned that these shops may be violating Federal cigarette laws and regulations by marketing their cigarettes as "healthier" and not appropriately restricting access to only those 18 and older. FDA has yet to assert its authority over the cigarettes produced in these shops. Is FDA aware of the proliferation of roll-your-own shops? Does the agency believe these shops are currently in violation of Federal law?

Answer. FDA is aware of retail establishments with roll-your-own cigarette machines that permit customers to make their own cigarettes and is gathering more information about this practice to determine the appropriate regulatory response.

Question. Under the Tobacco Control Act, the FDA has the authority to regulate tobacco products, but, without an important "deeming" regulation, the agency's jurisdiction extends to only a small set of products. Products like cigars, hookah tobacco, dissolvable tobacco, and electronic cigarettes remain unregulated by FDA, putting Americans' health at risk. Last year, FDA committed to issuing a "deeming" regulation by October 2011 that would extend its rightful regulatory authority over these of tobacco products. What is the status of this important regulation? Why is this regulation now 6 months overdue?

Answer. The Tobacco Control Act provided FDA with immediate authority to regulate cigarettes, cigarette tobacco, roll-your-own tobacco, and smokeless tobacco. The act also authorizes FDA to deem, by regulation, other tobacco products to be subject to chapter IX of the Food, Drug, and Cosmetic Act or FD&C Act. FDA has publicly announced its intention to deem all products that meet the statutory definition of tobacco product to be subject to the FD&C Act. Deeming would ensure that all tobacco products are subject to FDA's tobacco control authority, which will help to address existing regulatory gaps.

In the February 2012 edition of the Unified Agenda, FDA included an entry for a proposed rule that would deem products meeting the statutory definition of "tobacco product" to be subject to chapter 9 of the FD&C Act.

While FDA cannot comment on the details of pending rulemaking, FDA continues to work diligently to issue the proposed rule in the near future. It is important to note that the process for issuing any proposed rule on this issue will provides the opportunity for public comment as part of the rulemaking process. FDA routinely allows a minimum of 60 days for public comment and carefully considers these comments when it develops the final rule.

CONCLUSION OF HEARINGS

Senator KOHL. This hearing is recessed.

[Whereupon, at 3:24 p.m., Thursday, April 19, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]